King County Mental Health, Chemical Abuse and Dependency Services Division

Substance Abuse Prevention and Treatment Annual Report 2012

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Table of Contents

Department of Community and Human Services
Jackie MacLean, Department Director

King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD)
Amnon Shoenfeld, Division Director
Jim Vollendroff, Assistant Division Director/Drug and Alcohol Coordinator

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Message from Jim Vollendroff

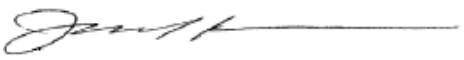
I went back into the archives as I started to write this and realized that I was hired for my first job in the field of substance abuse in 1983 when I was 19 years old. I was hired by Catholic Community Services in August of 1983 to work graveyard as a detox attendant in Grays Harbor County. It is hard to believe that was 30 years ago! I have witnessed firsthand the tremendous change our field has undergone and the substantial progress made towards genuinely legitimizing the contributions that addiction professionals offer towards the health of individuals with substance use disorders.

Although it took 30 years, I would like to think we have finally arrived! The Affordable Care Act (ACA) will revolutionize the field of substance abuse treatment. Finally, substance abuse treatment and other behavioral health interventions will be fully integrated into health care. Between the ACA and the Mental Health Parity and Addiction Equity Act millions of Americans, including hundreds of thousands right here in our state, will have access to substance abuse treatment for the first time.

Under the ACA, there will be more focus on prevention. Substance abuse treatment is considered an essential service, meaning health plans are required to provide it. We will shift to treat the full spectrum of the disorder, including people who are in the early stages of substance abuse – something, due to funding limitations, we were only able to do on a limited basis. In the near future, there will be more prevention, early intervention and treatment options, which will result in better outcomes at a lower cost.

I continue to be proud of the quality, range and diversity of services we provide in King County – made possible by the leveraging of local resources and the broad partnerships that we have developed. It is a time of opportunity where we challenge ourselves to take bolder actions and create bigger goals, to make our system even better. In these pages, you will read about our new and ongoing initiatives and results.

We look forward to your support and partnership as we fulfill King County's mission of providing fiscally responsible, quality-driven local and regional services for healthy, safe and vibrant communities, and move towards the County's vision of an environment "where all people… have the opportunity to thrive."



Jim Vollendroff, MPA, NCACII
Assistant Division Director/Drug and Alcohol Coordinator
King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD)

Recovery and Resiliency-Oriented Behavioral Health Services Ordinance and Plan

Recovery has long been the foundation of substance abuse treatment. Originally synonymous with abstaining from drug use, the concept of recovery has evolved to one of transformation, where individuals are living meaningful lives, striving to achieve their full potential. Several years ago the King County mental health system began embracing this concept of recovery and in 2005 the King County Council passed a mental health recovery ordinance that assisted in transforming the mental health system to a recovery orientation. As views of recovery and resiliency (the ability to overcome challenges) have evolved and understandings of the intersection of mental health and substance abuse have deepened, a more comprehensive behavioral health plan is in order.

In April 2013, the King County Council unanimously passed King County Ordinance 17553. This Ordinance directs the King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) to implement the Recovery and Resiliency Behavioral Health Services Plan 2012 – 2017.

Ordinance Overview

- Updates language in the ordinance to better reflect what is known and understood about recovery from both mental illness and substance use disorders.
- Explicitly adds resiliency as a concept that more appropriately applies to children, youth and older adults.
- Incorporates recovery from substance use disorders into a more comprehensive behavioral health system plan.
- Includes the value of trauma-informed care, as trauma is both a predictor of mental illness and substance abuse and often a result of those disorders.
- Calls for annual progress reports on the status of strategies and goals, outcomes, and performance measures.

Plan Overview

- Stakeholders, especially the people served, are included in planning, implementation and monitoring of all system changes.
- The plan identifies three phases of change with multiple strategies in each. These three phases are:
    - Building a shared vision of recovery
    - Initiating change
    - Increase depth and complexity

- Strategies for the substance use disorders treatment system include the following:

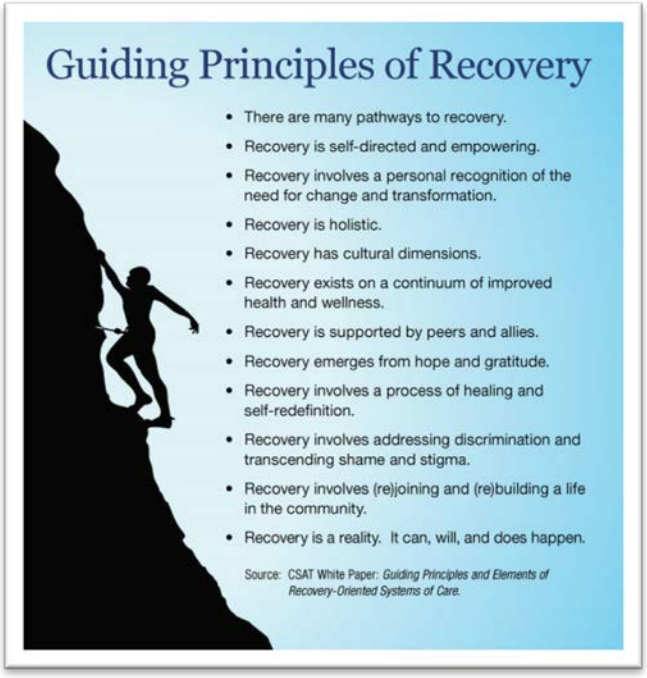
    - Review and change policies and contracts to support recovery and resiliency-oriented services and ensure person-first language. Develop and implement standards of practice.

    - Work with funders to realign resources to support incentives for system change; engage treatment providers in system improvement via a self-audit, identify appropriate incentive measures; require participation in incentive measures via contract; and fine tune measures as indicated.

    - For both mental health and substance use disorders treatment providers, work with stakeholders to identify and implement a method of measuring individual progress toward recovery.

    - Continue to support the learning collaboratives for motivational interviewing and other topics to support a Recovery-Oriented System of Care (ROSC). Present fundamental concepts of recovery via online learning made available to the workforce. Work with the state to develop and invest in peer services, sometimes called recovery coaching.

    - Support grassroots pressure for change via events for people in recovery such as conferences, celebrations, picnics, etc.; outreach and provide education to the community; provide encouragement to consumer-run organizations; and explore and utilize social media to promote social inclusion and the reduction of internal and external stigma.



2012 National Recovery Month Accomplishments

September is National Recovery Month, an event coordinated nationally by the Substance Abuse and Mental Health Services Administration (SAMHSA) in partnership with local communities. MHCADSD led a busy and vibrant recovery month in 2012, focusing on recovery from substance abuse and from mental illness.

Of 39 King County cities and towns, 30 issued recovery month proclamations that have been listed on the King County and SAMHSA websites. Word about King County recovery events and efforts was also spread through an article on the Reclaiming Futures website, the White House Office of National Drug Control Policy blog, the NIATx Facebook page, and through inserts into King County pay checks. Letters encouraging participation in Recovery Month were sent to mental health and substance abuse treatment providers, universities, allied providers, public health centers, hospitals, school superintendents and ministries. There were 9 recovery events and 27 City Council meetings where recovery was discussed throughout King County during the month of September 2012.

MHCADSD held two of its signature events during the month. The first was the annual King County Behavioral Health Conference, whose theme was "On the Journey Together for Recovery, Resiliency, and Wellness." The conference offered 41 workshops, many of which featured co-presentations by peer support specialists and behavioral health professionals. About 300 individuals attended the well-received conference.

The second event was the MHCADSD annual Exemplary Service Awards for people and organizations who have demonstrated leadership in advocacy, peer support, system integration, service innovation and direct service excellence in the fields of either substance abuse or mental health support. Michael Hanrahan, HIV Education and Prevention Services Manager for Public Health – Seattle & King County, who manages the needle exchange program and the waitlist for entry into medication-assisted opiate treatment programs, received the 2012 advocacy award. Winners of the recovery poster contest and of the new recovery poetry contest were also celebrated.

King County

PROCLAMATION

WHEREAS, substance use and mental illness are serious health problems affecting millions of Americans of all ages, races, and income levels, and across all communities; and

WHEREAS, behavioral health is essential to overall health and wellness; and

WHEREAS, substance use and mental illness are treatable, and people should seek treatment for these conditions with the same urgency as they would any other health condition; and

WHEREAS, the benefits of prevention and treatment are significant and people in recovery achieve healthy lifestyles, both physically and emotionally, and contribute in positive ways to their communities; and

WHEREAS, Recovery Month is an opportunity to share the message that prevention works, treatment is effective, and recovery is possible.

NOW, THEREFORE, I, Dow Constantine, King County Executive, do hereby proclaim the month of September, 2012 to be

Recovery Month

in King County and call upon all residents to join me in recognizing, celebrating, and supporting this year's theme, "Join the Voices for Recovery: It's Worth It."

Dow Constantine
King County Executive

King County SAMHSA-Supported Initiatives Demonstrate Positive Results

King County is currently participating in five substance abuse related initiatives supported by grants from the *Substance Abuse and Mental Health Services Administration (SAMHSA).* These include building capacity for implementing evidence-based practices in drug treatment for adolescents, drug treatment for transition-aged youth, juvenile drug court, drug treatment for pregnant and parenting women, and for integrating universal screening for early substance abuse and co-occurring mental health issues in primary care settings.

Recovery-Oriented System of Care for Pregnant and Parenting Women (ROSC-PPW)

The University of Washington, School of Medicine through the Department of Psychiatry and Behavioral Sciences Fetal Alcohol and Drug Unit Parent Child Assistance Program serves as the local evaluator for the King County Recovery-Oriented System of Care Pregnant Parenting Women (ROSC-PPW) Treatment Project. The ROSC-PPW Treatment Project is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). Evaluation is based on three data sources: Global Appraisal of Individual Needs Quick version 2.6.2 (GAIN-Q); Government Performance and Reporting Act (GPRA) questions, and the Time and Activity Log that tracks the contact's duration and nature. Preliminary outcomes based on 236 six-month follow-up interviews completed through August 2012 indicate positive results from the intervention, including improvements in housing, employment, mental health and family interactions. Decreases in alcohol and drug use, risky sexual behaviors, and criminal justice involvement are also noted. The final report is scheduled to be completed in late 2013.

Assertive Adolescent and Family Treatment AAFT3

The King County Assertive Adolescent and Family Treatment 3 Grant, locally named ***Keys to Success***, uses two evidence-based treatment approaches: the Adolescent Community Reinforcement Approach (A-CRA) coupled with Assertive Continuing Care (ACC). The goal of A-CRA is to improve or increase access to social, familial and educational/vocational reinforcers for adolescents to achieve and sustain recovery. In other words, therapists assist adolescents/transition-age youth with learning how to lead enjoyable and healthy lives without using alcohol or drugs. The intervention employs structured "procedures" sessions, with or without additional family involvement, that focus on specific life areas. The ACC provides three months of post A-CRA treatment support. This program has been implemented at the Youth and Family Services (YFS) branch of Therapeutic Health Services (THS). YFS is 1 of 14 sites nationally that implemented A-CRA/ACC with transition-age youth (ages 18-24) as part of the Substance

Abuse and Mental Health Services Administration (SAMHSA) Assertive Adolescent and Family Treatment (AAFT 3) Grant program. The contract was administered by King County Mental Health, Chemical Abuse and Dependency Division (MHCADSD). The formal grant period is winding down and will end in March 2013.

Keys to Success has accomplished much during the past three years:

1. ***Keys to Success*** met its goal of engaging 105 transition-age youth in A-CRA/ACC treatment services between January 2010 and September 2012.

2. Four counselors were trained and certified in A-CRA/ACC over the course of the grant. One clinical supervisor achieved both A-CRA certification and A-CRA supervisor certification and will continue providing A-CRA supervision and training after the grant ends.

3. Counseling sessions were reviewed for model fidelity by Chestnut Health Systems and the project's clinical supervisor. Counselors participating in clinical review achieved fidelity to the A-CRA/ACC model.

4. A-CRA/ACC was successfully integrated with other outpatient treatments such as opioid replacement therapy and group-based treatment administered within Therapeutic Health Services (THS) for one-fifth of participants.

5. Clients were receptive to the A-CRA treatment model and rated their ***Keys to Success*** counselors highly in client satisfaction surveys.

6. Statistically significant improvements in substance use rates from prior to enrollment to 3, 6, and 12-months after treatment initiation were seen for marijuana, crack cocaine and alcohol and were similar to results at other AAFT3 sites around the country that served transition-age youth. Statistically significant improvements were also seen in both internalizing and externalizing disorder symptoms, with reported depression rates cut in half at 90-day follow-up.

7. For ***Keys to Success*** clients, notable improvements from enrollment to follow-ups were seen in clients' economic stability, with participants more likely to be employed and supported by earned income at the follow-up periods than at intake. There was more than a five-fold reduction in youth depending on family as a primary source of support by the 12-month follow-up.

8. THS will continue to provide A-CRA/ACC services beyond the end of the AAFT3 grant as part of its youth outpatient, juvenile drug court and young adult drug court programs. They are interested in broadening their use of this evidence-based practice, subject to both funding and clinical need.

Assertive Adolescent and Family Treatment AAFT4

The King County Assertive Adolescent and Family Treatment Project expanded a countywide, multi-year effort to implement evidence-based practices throughout the county substance abuse provider network. King County has forged a successful partnership with the Center for Human Services (CHS), a local community-based contracted substance abuse/mental health provider to implement the Adolescent Community Reinforcement Approach (A-CRA) coupled with Assertive Continuing Care (ACC) with youth ages 12-17, their families and, where appropriate, significant others, mentors or other relevant adults. All staff members have been trained and three of the five staff became A-ACRA and ACC certified, assuring implementation with fidelity. This program builds on the Division's initial success with the AAFT program and expands the model from transition-age youth (18-24) to adolescents (12-17).

Treatment services focus on the interaction between youth and their environments and family (as defined by the participant). Strategies and intervention focus on developing problem-solving skills to cope with day-to-day stressors, communication skills and active participation in positive social and recreational activities. The goal is improving life satisfaction without drugs. Field and strengths-based case management, along with home visits, are used to reinforce engagement and adherence to treatment goals, and increase the likelihood of family and participant success.

Goals for the project include reducing substance abuse, implementing the A-CRA/ACC model with fidelity, and expanding use of the Global Appraisal of Individual Needs (GAIN) assessment to youth ages 12-17. Client enrollment is on track with 63 enrolled as of the end of 2012.

The University of Washington, Division of Public Behavioral Health and Justice Policy (PBHJP) serves as the local evaluator for the Assertive Adolescent and Family Treatment Grant for youth. The Assertive Adolescent and Family Treatment (AAFT) project is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). Evaluation is based on three data sources: Global Appraisal of Individual Needs Initial version; Government Performance and Reporting Act (GPRA) questions, and key informant interviews and surveys. Preliminary results indicate that there are clinical improvements in depression, anxiety, and in improvements in past month substance abuse as measured at three and six months. The final evaluation report is expected to be completed in late 2013.

Evidence-Based Programs Making a Difference

Ashley (not her real name) was referred to the Circles of Recovery (CORe) program at Community Psychiatric Clinic (CPC) because she wanted more help coping with her Bipolar and Post Traumatic Stress Disorder (PTSD) symptoms. She had come to a point in her life where she had decided that things needed to change in a positive direction. She had a previous history of numerous arrests for assault and had lost custody of one child related to her untreated mental health and substance dependency. She had just completed an intensive inpatient chemical dependency program at Perinatal Treatment Services and was starting her journey towards being clean and sober in the community. She had gotten back on medication to control her Bipolar disorder and moved into a clean and sober recovery house. She wanted more than anything to become reunited with her two-year old son who had been in foster care since birth, due to her long history of methamphetamine use.

The CORe therapist worked with Ashley to develop new coping skills that that would help her stay on track with her goals. They used evidence-based therapy to address PTSD symptoms and emotion regulation. Ashley showed eagerness and willingness to participate in these sessions. Additionally, they worked on improving her parenting and self-advocacy skills. Ashley also worked with CPC's CORe Peer Support Specialist to get connected to permanent housing, daycare, and school resources to obtain her GED.

Ashley worked hard to meet CPS requirements. She took every opportunity to visit her son, even though he was living in foster care more than 60 miles away. She didn't have a car, so visiting him required traveling by a series of buses that took three hours each way. Eventually, Ashley met all of the CPS requirements and was given custody of her son. Today she is clean and sober and continuing to work at being the best possible mother she can be. She wants to finish school and get a job to support herself and her son.

Susan (not her real name) is a woman in her twenties who experienced physical and emotional trauma from a severe domestic violence assault. Prior to this incident, she had been self-sufficient with a good paying job and strong work history. She had never been in an abusive relationship before and was shocked and embarrassed to have found herself isolated and in this situation. The assault resulted with her being hospitalized for two weeks and she endured another six months of rehabilitation. During the hospitalization she also found out she was pregnant. The perpetrator was charged with attempted murder and sent to prison. However, she was unable to resume her prior life as she had lost her job, incurred medical and rental debts and now had a baby to care for. Psychologically, she continued to re-experience the trauma of the abuse with self-doubt, mood swings, difficulty sleeping, and violent nightmares. She began to self-medicate with marijuana. Susan's path started to change when she moved into a domestic violence transitional housing program and enrolled in a community college. Yet the emotional trauma and the drug use persisted.

Susan was referred to the Circles of Recovery (CORe) therapist at Community Psychiatric Clinic for mental health services by a public health maternity nurse due to her severe symptoms of Post Traumatic Stress Disorder. When the CORe therapist started working with Susan, they began by practicing relaxation and self-soothing skills. The therapist provided information about the effects of trauma, domestic violence, and how therapy could help. She referred Susan to a domestic violence survivor's group where Susan began to understand that she was not alone and developed a growing sense of self-confidence. She became passionate about spreading the warning signs of domestic violence. The therapist also referred Susan to a co-occurring disorders program to address her marijuana use. In therapy, the CORe therapist and Susan used evidence-based cognitive behavioral therapy to continue to build her self-esteem and addressed the intrusive memories that she had been re-experiencing with exposure therapy. Today, Susan does not use marijuana, has fewer intrusive memories and can emotionally cope with the remaining symptoms. She is graduating with an associate's degree from community college, and is moving into permanent housing. She is looking forward to raising her son and being self-supporting.

Washington State Screening, Brief Intervention and Referral to Treatment – Primary Care integration (WASBIRT – PCI)

MHCADSD is partnering with the Washington State Department of Social and Health Services' Division of Behavioral Health and Recovery (DBHR) and Research & Data Analysis (RDA), and with Public Health – Seattle & King County (PHSKC) to implement year two of a five-year, $8.3 million federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant that was awarded to Washington State in 2011. The funds were awarded to DBHR who subcontracted with MHCADSD to coordinate implementation in King County.

Funding is being used to support primary care clinics in providing Screening, Brief Intervention and Referral to Treatment (SBIRT) services for alcohol and other drug use to adults receiving primary care in selected health clinics. The project is expected to reduce alcohol and other drug consumption and their negative health impacts, increase abstinence, and reduce costly health care utilization.

Beginning in January of 2012, four primary care clinics began providing SBIRT services. Those clinics included Public Health North, Downtown Public Health, SeaMar Burien and SeaMar Seattle. The four clinics were phased in from January to May, with the Downtown Public Health Clinic being the first to begin screening. The process included a universal prescreen for alcohol and other drug use for all adults seen at the clinic. For those whose prescreen indicated that further assessment was warranted, the AUDIT and/or DAST-10 was administered as a more comprehensive screening. Based on AUDIT and DAST-10 scores, patients received interventions that included a positive health message and reinforcement for those at low to no risk, brief counseling sessions provided by a clinic-based behavioral health specialist, and referrals to substance abuse treatment agencies for more in-depth assessment and/or treatment for those who scored as highest risk. Due to the rates of co-occurring substance use and mental health disorders, anyone who scored as a risky drinker/drug-user or above was also screened for depression and anxiety using the PHQ-9 and GAD-7, both of which are validated standardized assessments.

Throughout 2012, 10,907 adults received a prescreen at one of the four clinics. Of those, 1,415 people prescreened positive for needing additional assessment, 502 scored in the range for a brief intervention and 212 scored for a referral to brief or extended treatment.

The project experienced many successes in 2012 in addition to the number of patients screened:

- MHCADSD partnered with DBHR to revise the Medicaid State Plan to include SBIRT Billing Codes and credentials. This will be effective January 1, 2014 and will allow clinics to be reimbursed for screening, paving the way for broader adoption of this evidence-based practice.

- SBIRT screening was included as a requirement by the state in Medicaid Healthy Option Plan contracts.

- Healthy Options plans will be requiring their contracted providers to adopt the current WASBIRT protocol and screening tools as part of their standard practice.

- WASBIRT program staff is partnering with Healthy Options plans to create a training plan and fidelity guidelines for billing Medicaid codes.

- Ongoing training and coaching was provided for Behavioral Health Intervention Specialists located at each of the clinics to strengthen motivational interviewing, brief intervention and referral to treatment intervention skills.

The timing for receiving this grant was very opportune. SBIRT screening is an integral part of health care reform and provides an ideal transition point for beginning integration of primary care and behavioral health. Over the past 10 years, SBIRT has demonstrated effectiveness for improving health outcomes while significantly reducing health care costs. Because of this, SBIRT screening has been given a B grade rating from the US Preventative Task Force. SBIRT was also included as one of the 10 essential health benefits in the Affordable Care Act. With the momentum of both of these key factors, SBIRT is becoming recognized as a standard practice within primary care and reimbursement for services is becoming available. The grant funding has allowed the primary care clinics to move forward in implementing SBIRT screening in a thoughtful way that is integrated within the clinics, ensuring long-term sustainability.

In addition to the grant funded WASBIRT program, King County continued the emergency room SBIRT initiative in King County that was initially supported by a SAMHSA grant, using local MIDD tax dollars. SBIRT screening is currently happening in three emergency departments: Harborview, Highline Hospital and St. Francis Hospital. These hospital emergency departments provided SBIRT screening to 3,948 patients in 2012.

Access to Recovery (ATR)

Access to Recovery (ATR) is a federally funded grant for recovery support in its third four-year cycle. Participants stay with ATR for a six-month period as they engage with community support for their individual recovery goals. King County has focused ATR resources to further develop the local recovery-oriented system of care. There are three main elements to the program:

1. Recovery-based housing for persons with chronic substance use disorders. Adults returning from involuntary treatment at Pioneer Center North are eligible for funding to enter recovery-based housing to increase their recovery capital as they develop new support in the community.

2. Faith-based recovery services are provided by Teen Challenge, a Renton program that works with adult males. People choosing Teen Challenge can stay for up to a year in a residential program.

3. Peer-to-peer services at the Recovery Café. Recovery Café is a recovery support center utilizing an alternative therapeutic community model. In a beautiful space, the Café supports women and men who are seeking a life of transformation, free from drugs, alcohol and other destructive behaviors.

During 2012, 608 people were enrolled in King County ATR programming.

Moving Towards Clinical Excellence

Reclaiming Futures and Implementing Standardized Assessments

When the Robert Wood Johnson Foundation launched its *Reclaiming Futures* Initiative in 2001, King County was selected through a competitive process to be one of the original 10 sites around the country to receive a *Reclaiming Futures* Grant. *Reclaiming Futures* is a systems approach to provide: 1) more treatment; 2) better treatment; and 3) beyond treatment for young people caught in the cycle of drugs, alcohol and crime. The initial project was designed to promote integrated, community-based systems for delivering substance abuse interventions in the juvenile justice system. There are now 29 *Reclaiming Futures* sites across the country.

The Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) has taken the *Reclaiming Futures* six-step model and expanded it to all youth providers receiving public funding for substance abuse treatment in King County. Through the process of implementing *Reclaiming Futures* in King County, the publicly supported youth chemical dependency delivery system has been transformed. One of the greatest accomplishments has been the implementation of a standardized assessment, the Global Appraisal of Individual Needs (GAIN), across the entire adolescent system of care. The King County system of care consists of 15 independent non-profit treatment agencies providing substance abuse treatment and assessment services to more than 700 youth at any given time.

Through the collaboration with *Reclaiming Futures*, the first glaring needs identified by the community led to the decision to standardize the youth assessment tool and process for the following reasons:

- MHCADSD had 15 youth treatment providers all using different assessment instruments to assess and make patient placement, transfer, continued stay and discharge decisions. This made it impossible to compare the quality of assessments across providers.
- Providers were using non-validated assessment tools that were questioned by the legal system.
- MHCADSD had no solid data on co-occurring mental health issues. MHCADSD staff knew that providers were serving youth with co-occurring disorders, but had no solid data or process to collect information on co-occurring youth across providers.
- The overall quality of assessments was inconsistent. Quality review identified that there were significant differences in the level and comprehensiveness of individual agency assessments. Some assessments were simply focused on the youth's use of substances and did not address the youth from a holistic perspective.
- Quality reviews indicated the need for better documentation of issues identified during the assessment and better linkage between these issues and the treatment plan.
- Multiple assessments were conducted on the same youth. If a youth received their assessment at one agency but ultimately enrolled in treatment with another provider, the youth was

"My life without mentoring – without Hazel… I would be back where I was and I wouldn't have the support to stay off the streets and stay in school… it could have been really bad."

-24-year-old youth

reassessed by the second agency. This was both an inefficient use of resources and an unnecessary burden for youth and their families.

- MHCADSD had no data to support implementation of evidence-based practices. Without solid data it was challenging to identify system gaps and new programs to implement.

- MHCADSD wanted to position King County to be able to competitively apply for grants.

The Global Appraisal of Individual Needs (GAIN) is a family of science-based chemical dependency assessments used with both adult and youth patients in outpatient, intensive outpatient and residential substance abuse services (http://www.gaincc.org/). It is used as the core clinical and evaluation measure allowing views of client change, program effectiveness and systemic issues and challenges.

The GAIN has eight core sections (Background, Substance Use, Physical Health, Risk Behaviors and Disease Prevention, Mental and Emotional Health, Environment and Living Situation, Legal, and Vocational). Each section contains questions on the problem recency and symptom breadth. The items are combined into over 100 scales and subscales that can be used for Diagnostic Statistical Manual (DSM) diagnoses and American Society of Addiction Medicine (ASAM)-based level-of-care placement.

These tools have provided King County with the infrastructure to build an adolescent treatment system based on science, with quality assurance measures to ensure improvements to the system as needed. The GAIN provides a standardized clinical assessment that providers use in the diagnosis, placement, and treatment planning process for patients receiving services within our provider network.

Building consensus among providers for selecting a single system-wide assessment tool was no easy task. The process that MHCADSD used to engage the chemical dependency provider community was integral to the successful implementation of this new assessment tool. King County and provider representatives selected the GAIN from a variety of options. The GAIN was ultimately chosen because it: is a validated instrument, is comprehensive, has a certification process and ongoing quality assurance processes to ensure its use with fidelity, and has follow-up assessment versions to track client change.

By the end of 2012, MHCADSD had nearly 10,000 baseline assessments completed throughout our adolescent system, 1,324 of which were completed in 2012. Due to the reliable, valid data and clinical relevance, MHCADSD could describe adolescents' trends of drug use, rates of trauma, and co-occurring mental health issues without compromising confidentiality. This real-time data provides immediate and accurate numbers for federal, state and local grants and helps target funding opportunities based upon real needs in the community. More importantly, it allows clinical care for the youth assessed to be optimized.

MHCADSD is now in its seventh year of GAIN implementation and has learned that the implementation of evidence-based practices is a process, not an event. The Division continues to make adjustments to policies and procedures as new issues are identified that were not apparent from the beginning. Some things MHCADSD has done right to build large scale GAIN implementation:

- Trained providers prior to implementation.

- Implemented the GAIN incrementally, with the timetable known in advance and technical assistance made available.

- Increased the fee for service vendor reimbursement rate for providers for assessments completed using the GAIN versus those completed with non-validated instruments.

- Gave each agency a laptop to use during the startup phase of implementation.

- Created a group of local GAIN trainers and now contract with providers to conduct local trainings as staff turnover occurs.

- Convened a quality assurance group that meets quarterly to address challenges and request changes.

- Written GAIN use into county policy and procedures and Requests for Proposals released to the youth provider community.

- Implemented online training for the GAIN-I. This distance learning approach to training is a major efficiency with quality assurance built in, making training more affordable and individualized. Through this approach, MHCADSD is eliminating the need for: 1) staff time and paper resources spent in a two-day training for treatment providers; 2) travel and parking downtown for non-profits from all over the county; and 3) training delays for new staff. Online training includes self-paced online coursework and is supplemented with conference calls, webinars, one-on-one coaching, practice with the GAIN Administration Quality Assurance Team and tape review for fidelity.

The State of Washington now requires use of the GAIN-Short Screen as a standardized screening tool for all clients served by the publicly funded mental health system, as well as those served by the chemical dependency system.

"***Treatment gave me that time to turn around… they helped me get back with my family.***"

-16-year-old youth

Results

- Since becoming a *Reclaiming Futures* site eleven years ago, King County has seen an incredible increase in treatment retention rates; King County currently leads the state in youth treatment retention. Treatment retention has been demonstrated in multiple studies to be linked with better client outcomes.

- The court system has become one of the biggest advocates of the standardized assessment process due to both assessment quality and consistency across the provider network. Agency staff report that they feel confident when called into court to defend a diagnosis. Assessment "shopping" (undergoing multiple assessments to get the result you want) has been reduced.

- MHCADSD can document the nature and the scope of co-occurring disorders affecting youth in the substance abuse treatment system, identifying numbers, diagnoses and impact.

- Agencies have modified programming as a result of obtaining more comprehensive pictures of their clients. For example, one provider now offers gambling addiction treatment as a result of using this more comprehensive assessment tool.

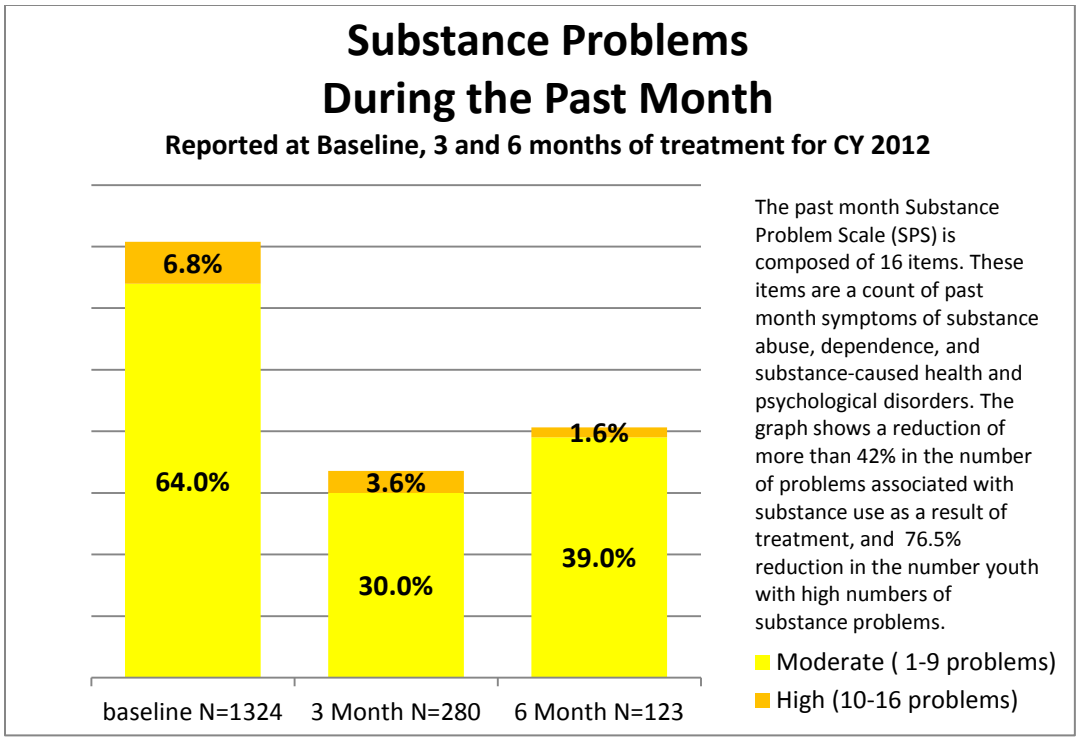
- MHCADSD now uses data to implement additional evidence-based practices within the County network. Treatment decisions, including which evidence-based practices to use with a particular youth, are based in large part on assessment data.

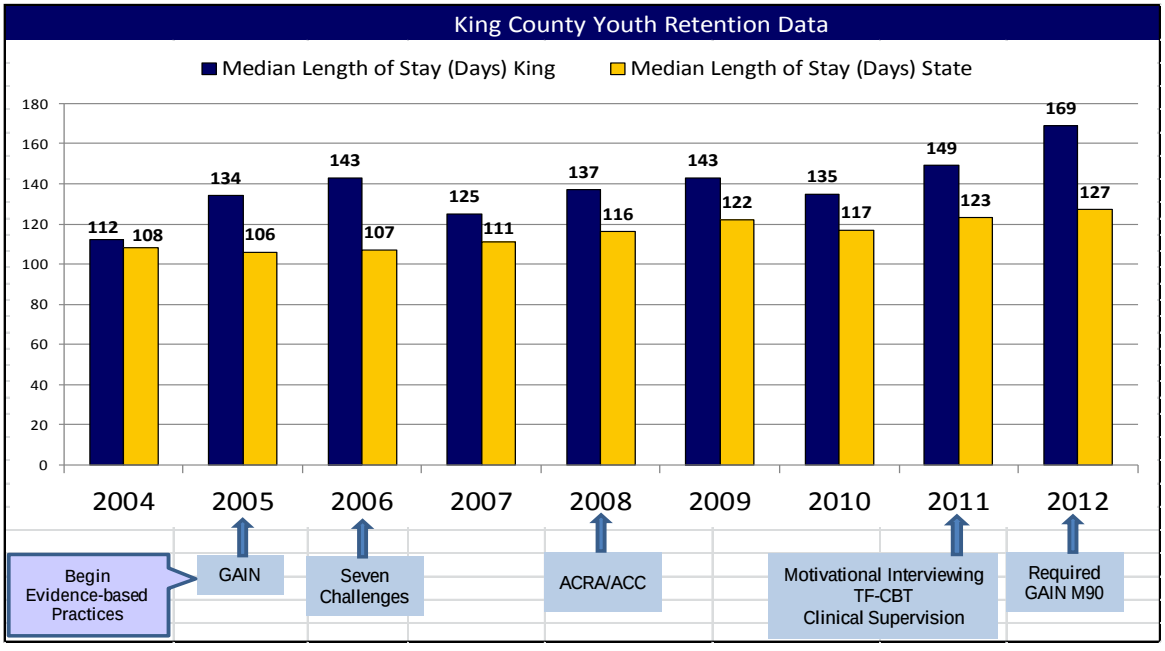
- MHCADSD now uses solid, timely, accurate data to support new grant applications.

As the County gathers better client data and increases access to science-based training, community providers develop better treatment plans, leading to better treatment outcomes. The King County adolescent treatment system can also effectively identify gaps in service and the most relevant evidence-based practices to implement.

Since King County implemented the *Reclaiming Futures* Model, the provider network has continued to improve their skills. Clients have benefited as evidenced by treatment retention and symptom reduction results.

Results from the GAIN Monitoring 90 Days (GAIN-M90), a quarterly follow-up assessment, bear this out. Current outcome measures of change over time that are monitored using the GAIN-M90 include changes in substance-related problems, changes in frequency of substance use, changes in health, changes in illegal activity, and changes in self efficacy. Youth who were treated in 2012 demonstrated substantial reductions in the number of recent substance use related problems, as shown in the following graph.





As a result of the rich data Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) now has on youth, the Division has implemented several additional evidence-based practices (EBPs), including some models that apply to adults as well (see chart below).

Evidence-Based Practices	Fidelity Checks	Who does the fidelity checks	How often	Comments
Motivational Interviewing	Specific tools monitoring taped client sessions that were developed to help ensure fidelity	Clinical Supervisor reviews the tapes, completes the evaluation tool, and offers feedback and instruction	Frequency is greater until the clinician reaches mastery, based on ratings of adherence and competence (usually done during the first and last 20 minutes of each counseling session)	MIA STEP (Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency) NIDA and SAMHSA produced
Adolescent Community Reinforcement Approach (A-CRA)	Certification includes tape reviews until competence is determined	Ongoing fidelity check is done by the certified A-CRA clinical supervisor based on tape reviews	Initial fidelity is ensured as part of certification (usually with reviews of up to 20 tapes); ongoing fidelity is ensured through clinical supervision and tape review done at random intervals	Chestnut Health Systems does the certification and provides the materials for both clinician and supervisor certifications
Moral Therapy (MRT)	Observed MRT sessions are reviewed with the MRT Certified staff against established measures of fidelity	King County – DCHS/MHCADSD currently contracts with Correctional Counseling Inc. for fidelity observations	Annually	Correctional Counseling Inc., or agency staff certified in Advanced MRT by Correctional Counseling, Inc., complete the fidelity checks
Seven Challenges	Certification through Seven Challenges LLC for clinicians and clinical supervisors	Seven Challenges, LLC facilitates quarterly conference calls and conducts annual site visits that include reviewing clinical documentation and observing group processes, providing written feedback to clinician, clinical supervisor and the County	Quarterly calls and annual visits	Seven Challenges, LLC owns the model and provides fidelity checks under contract with the County

Evidence-Based Practices	Fidelity Checks	Who does the fidelity checks	How often	Comments
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Certification is done via conference calls with senior clinical staff who are certified in TF-CBT	Senior clinician trained in fidelity evaluation and clinical supervision for TF-CBT	Monthly calls are required of clinicians	University of Washington, Harborview under contract with the County
Global Appraisal of Individual Needs (GAIN; family of screening and assessment tools)	Staff are trained and certified based on tape reviews. Local trainers are certified based on tape reviews of their review of individuals working to become certified; all staff certified have their final certification tape reviewed by Chestnut Health Systems; additional checks through quality review and edits of GAIN tools; all GAINs receive a quality review; additional quality improvement activities occur each quarter	Chestnut Health Systems, Local Trainers, and Regional Trainers	As needed until certification is reached; monthly data reviews, quarterly meetings and trainings based on an annual quality review and other documentation	Chestnut Health Systems under contract with the County, and county staff that have been certified as Regional and National trainers

Workforce Development

Developing a workforce of chemical dependency professionals (CDPs) and supervisors of adequate size with robust clinical skill and knowledge of evidence-based practices is a high priority for the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD). Designated funds from the Mental Illness Drug Dependency (MIDD) county sales tax support workforce training. In 2012, MHCADSD used these funds to contract with the Northwest Addiction Technology Transfer Center (ATTC) to provide the following trainings to the Substance Use Disorder Provider Network:

- Four Clinical Supervision workshops
- Five Clinical Supervision Learning Collaboratives, including training sessions
- Two Introduction to Motivational Interviewing workshops
- Two Advanced Motivational Interviewing workshops
- Five Motivation Interviewing Learning Collaborative Sessions, which included supervisory training to enhance counselor proficiency

Over 230 counselors attended these trainings or Learning Collaborative sessions. ATTC conducted pre- and post-training surveys of all participants and found that there were statistical increases in knowledge and skills among those who participated in Motivational Interviewing (MI) training and additional MI Learning Collaborative sessions. Anecdotally, participants expressed appreciation for training that was relative and immediately practical after training.

King County Alcoholism and Substance Abuse Administrative Board

The King County Alcoholism and Substance Abuse Administrative Board (KCASAAB) is a legislatively mandated volunteer board. The duties and responsibilities of the Administrative Board are to: 1) identify and examine all relevant data to determine the chemical dependency service needs and priorities of County residents to inform the biennial planning process; 2) advise the County Council on the administration of county-contracted funds for chemical dependency services; 3) to review biennial quarterly progress reports prepared by staff and monitor the implementation of the biennial plan on an annual basis; 4) to advise the County Council on chemical dependency treatment and prevention service policy, priorities, and programs; and 5) review and recommend plans, budgets and applications submitted by the County to the State Department of Social and Health Services. The Board works closely with the King County Substance Abuse Coordinator to meet these responsibilities.

Eleven volunteers served on the Board in 2012. Members participated in 10 full board meetings, including two retreats, and four Legislative Policy and Public Affairs Committee meetings. This committee develops legislative priorities and establishes legislative goals. Board members regularly attend the meetings of other county groups and organizations that interact with individuals with substance abuse problems. These groups include Chemical Dependency (CD) Youth, Adult and Prevention providers, CD Youth Executive Directors, and the Mental Health Advisory Board (MHAB). Board members also attended the first annual MHCADSD All Providers Meeting. The Board continues to be represented at the Mental Illness and Drug Dependency Oversight Committee, with a KCASAAB Board member serving as Chair of the MIDD Prioritization Sub-Committee.

Board members were kept abreast of timely topics such as marijuana legislation, the state substance abuse budget, the County recovery ordinance and youth opiate abuse through meeting briefings. The Board also co-sponsored important MHCADSD community events, including the annual MHCADSD Exemplary Service Awards Celebration that recognized outstanding work by service providers and community volunteers and the Community Legislative Forum.

Board members for 2012 included: Pat Godfrey, Public Affairs Consultant, Retired Senate Staff Chair; Therese Grant, Chemical Dependency Professional, Vice Chair; Linda Brown, Research Scientist, Volunteer; Joan Clement, Retired Social Worker; Roger E. Goodman, Director, Drug Policy Project, King County Bar Association, 45th District Legislator; Jim Benbow, Associate Director, VA office; Ruvin Munden, Activities Coordinator for 12-step recovery group; Kevin Kincaid, Family Advocate/Interested Citizen; Mary Ann LaFazia, Retired, Chemical Dependency Professional; Sarah Swenson, Chemical Dependency Professional.

WA State and King County Opiate Trends

According to the University of Washington's Alcohol and Drug Abuse Institute, Washington, like much of the United States, has seen increases in the use and harms associated with opiates. King County data show an increase in deaths involving heroin among those under 30 years old in 2012.The rate of all opiate deaths (heroin and/or prescription-related) has nearly doubled in the past decade.

For some, abuse of prescription opiates (for example, morphine, vicodin, oxycodone) leads to heroin use, so preventing inappropriate use of prescription opiates is important. All opiate overdoses can be prevented and most can be reversed before they become fatal if immediate action is taken (for more information, see http://stopoverdose.org/). Data for all treatment admissions in Washington state and King County show that heroin was the most common drug contributing to treatment admissions in 2012 among 18 to 29 year olds. First time admissions to treatment indicate that the growth in heroin admissions is driven by young adults.

In June of 2012 King County, in partnership with the Science and Management of Addictions (SAMA) Foundation, brought together experts from around the country to Seattle to develop a treatment protocol to manage the unique needs of this population. In 2013 we plan to begin piloting and testing this new protocol.

King County Opiate Treatment Expansion

In 2012, King County began an initiative to expand Opiate Treatment Program (OTP) access. This expansion is in alignment with the King County Strategic Plan, the Equity and Social Justice Initiative, and the Recovery Ordinance. The need for expansion resulted from:

- Lack of capacity at current OTP locations and long waitlists for OTP services
- An emerging population of youth and young adults addicted to opiates
- Absence of OTP services in east and south King County with more than 600 individuals traveling daily from east and south King County to downtown Seattle for OTP services
- Excessive Medicaid transportation costs for those traveling to downtown Seattle for treatment
- Pending tolls on I-520 and potential tolls on I-90

In July of 2012, MHCADSD supported the opening of a new OTP in Bellevue, operated by Therapeutic Health Services. Although zip code data indicated more individuals traveled from south King County to downtown for OTP services, expansion to east King County was prioritized due to the new tolls on Highway520 creating additional economic hardship for low-income individuals traveling to Seattle for treatment. Expansion efforts will continue in 2013 to south King County.

Sobering Center/Emergency Services Patrol News

The Dutch Shisler Service Center, known throughout the community as The Sobering Center, is an important recovery entry point in King County's recovery-oriented system of care. The center, originally intended as a sleep-off center for people who are publicly inebriated, has evolved into much more. Multiple organizations, including Pioneer Human Services (PHS) and REACH, provide services on-site. In 2012, people using sobering services also obtained additional services to further their recovery, including:

- 203 people were admitted to medical detoxification services on referral from PHS staff
- 100 people were admitted to treatment at Pioneer Center North through King County's involuntary substance abuse treatment process
- 374 people were referred to other substance use disorder treatment services
- 25 people moved into permanent supported housing at the Wintonia Hotel

Assisting sobering clients with accessing additional services has led to a reduction of overall sobering use and a reduction in the frequency of use by many individuals. Overall, 2,031 different people were admitted to sobering in 2012.

The Emergency Service Patrol (ESP) is a 24/7 transportation and engagement unit. The main duty of the screeners is to relieve fire, police, and medics from caring for chronic users. The screeners also patrol the downtown core, seeking out clients in need of service and linking them to recovery settings. Additionally, they transport clients away from sobering to other service providers. During 2012, ESP provided:

- 21,925 responses to requests for assistance
- 12,623 responses to calls from 911 operators
- 2,310 responses to relieve first responders
- 18,974 people transported

Prevention Redesign Initiative (PRI)

In mid-2012, Prevention Services transitioned entirely to the new Prevention Redesign Initiative (PRI) community coalitions that began in 2011. The PRI is the Washington State Division of Behavioral Health and Recovery (DBHR) plan to target limited prevention funds to communities facing complex challenges with higher than average rates of academic failure, economic deprivation and substance abuse.

There were 12 prevention organizations that provided 21 programs under the old prevention model provided services through the first half of the year. These organizations provided individual evidence-based services with fidelity to children, youth and families. See Appendix C for a list of these providers and the Prevention program section (p. 31) for data about the prevention programs they provided in the first half of 2012. State funding for these programs ended June 30, 2012.

In 2011, two coalitions began implementing the PRI and have completed strategic plans for their areas based on data reviews, surveys and other methods appropriate to their locale. They are Vashon Alliance to Reduce Substance Abuse (VARSA) in conjunction with McMurray Middle School and Vashon High School, and Central Seattle Drug Free Communities Coalition in conjunction with Washington Middle School and Garfield High School.

During 2012, two new coalitions joined the two coalitions from 2011 in implementing the Prevention Redesign Initiave. They are SE Seattle P.E.A.C.E. Coalition with Aki Kurose Middle School in the Seattle Public School District, and Coalition for Drug-Free Youth in unincorporated North Highline/White Center with Cascade Middle School and Tyee Educational Complex in the Highline School District. These coalitions will develop strategic plans in 2013.

Initiative 502 – WA Marijuana Legalization

In November 2012, Washington State voters passed I-502, a marijuana reform initiative, amid both concerns and support. Concerns included but were not limited to potential for increased youth access and promoting the use of drugs. Reasons for support included but were not limited to social justice issues such as racial inequity in arrests and penalties for use and possession of marijuana, and the large black market for marijuana that is active in all areas of our community with easy youth access.

For those over the age of 21, I-502 legalizes the use of marijuana and marijuana-infused products and possession of up to an ounce of marijuana product with no defined legal limit for possession of marijuana-infused products. It requires the Washington State Liquor Control Board (WSLCB) to establish a licensing process and rules for marijuana producers, processors and retailers. The WSLCB will issue an implementation timeline to include public hearings, draft rules with comment periods, and then final rules so that licenses for production and sale can be issued before the end of 2013. The law also requires taxation of marijuana sales and directs these revenues to be used for health care and substance abuse prevention and treatment.

Administrative Efficiency Enhancements

The Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) strives to make administrative activities as efficient and unburdensome as possible. One efficiency implemented in 2012 was allowing electronic signatures for contracts and amendments using Docusign. Site visit efficiencies included revising site visit documentation and using laptops to complete reconciliations. These changes shaved time needed by both agency and MHCADSD staff for completing these processes, allowing for more rapid processing of contracts and more streamlined site visits.

Recovery Innovations Workgroup

In June of 2012 King County, along with other counties and state partners, began working to identify opportunities to enhance our continuum of services under the Affordable Care Act (ACA). The joint vision of the Substance Abuse Section of the Association of County Human Services (ACHS) and DBHR is to deliver substance abuse prevention and treatment services in Washington State that meet the cultural, spiritual, emotional and physical health needs of patients and their families. The shared goals for the future are to close the treatment gap and deliver more treatment; implement better treatment that is evidence-based, and to supplement traditional treatment with essential supports such as patient navigation, care coordination, peer support, co-occurring services and other recovery support activities. The vision is a system that will be delivered in an integrated and coordinated manner, with services that are anchored in the patient's community, embrace the elements of a Recovery-Oriented System of Care (ROSC), include evidence-based practices delivered with fidelity and have clear performance expectations.

Services must be designed to meet the needs of individuals at any stage along a recovery-readiness continuum that ranges from not yet acknowledging they have a problem through maintaining long-term recovery. The service delivery model must also strive to meet the unique needs of small, medium, and large communities in all counties. The purposes of the work group were to guide, shape and inform DBHR policies, procedures and practices related to providing for the delivery of substance use disorder services in Washington State. To achieve our desired outcomes, we committed to developing broader partnerships, creating bigger goals for ourselves, using better data to make decisions and to take bolder actions.

Three subcommittees were developed to provide structure to our work and recommendations:

1. Systems Change (Chaired by Jim Vollendroff, King County)
2. Finance and Policy
3. Sustainability

Joint recommendations were made to DBHR and will continue to be considered as the ACA is implemented.

Chemical Abuse and Dependency Programs

Preventing and treating drug abuse and dependency is consistent with the King County Strategic Plan health and human potential goal of providing opportunities for all communities and individuals to realize their full potential, and fulfills all the strategic plan objectives allied with this goal.

Prevention

MHCADSD's work with substance abuse prevention is most closely aligned with the strategic plan health and human potential objective of supporting the optimal growth and development of children and youth.

During 2012, King County programs addressed drug and alcohol abuse prevention through three approaches. The first approach, facilitated by the King County Alcohol and Other Drug Prevention Program, was to contract with organizations to provide drug and alcohol prevention programs. This approach ended June 30, 2012. Beginning in July 2012, the Alcohol and Other Drug Prevention Program began implementing the second approach: the Prevention Redesign Initiative. This approach supports coalitions in selected communities with complex challenges. The third approach, facilitated by the Community Organizing Program, is supporting the development of community efforts to address substance abuse and violence.

Research has shown that risk factors and protective factors affect youth involvement with substance use. It is important to focus prevention efforts on youth as the majority of individuals who become chemically dependent are more likely to initiate their drug use at a young age. King County conducts a participatory planning process that includes community involvement to identify which factors to target with prevention programming. This planning process results in changes to factors prioritized and addressed by prevention programs over time. Factors addressed by contracted drug and alcohol prevention programs from January 2010 through June 2012 are:

- Favorable attitudes among youth that encourage substance use (risk factor)
- Family management problems due to inconsistent guidelines for behavior and inappropriate rewards and consequences for following and not following guidelines (risk factor)
- Warm, supportive relationships with parents, teachers and other adults and peers (bonding) who reinforce competence, expect success and support not using alcohol, tobacco or other drugs (protective factor)
- Early initiation of the problem behavior (risk factor)

During 2012, the new coalitions also addressed the risk factor of low neighborhood attachment.

This section first describes the King County Community Organizing Program (KCCOP) and presents 2012 data on KCCOP activities. It then describes the Alcohol and Other Drug Prevention Program (AODPP), as it was organized through June 2012, and presents data on AODPPs for half-year periods through June 2012. Except for data from single event programs, no data about community coalition activities will be reported until 2013.

The goal of the King County Community Organizing Program (KCCOP) is to involve every citizen of King County in preventing youth substance abuse and violence through community-based solutions. Using a community organizing model, KCCOP works with coalitions that form to address substance abuse or violence concerns within an identified community. Such communities are defined by the common identity or interests of their members, such as where they live or attend school, ethnicity, sexual orientation or particular prevention goals and strategies.

In 2012, KCCOP worked with a total of 46 community coalitions with 1,569 members to implement strategies for the prevention of substance abuse and violence.

For contracted AODP programs, the target populations were children, youth and parents. Programs were designed to prevent or delay first use and abuse of alcohol and other drugs by reducing risk factors and enhancing protective factors.

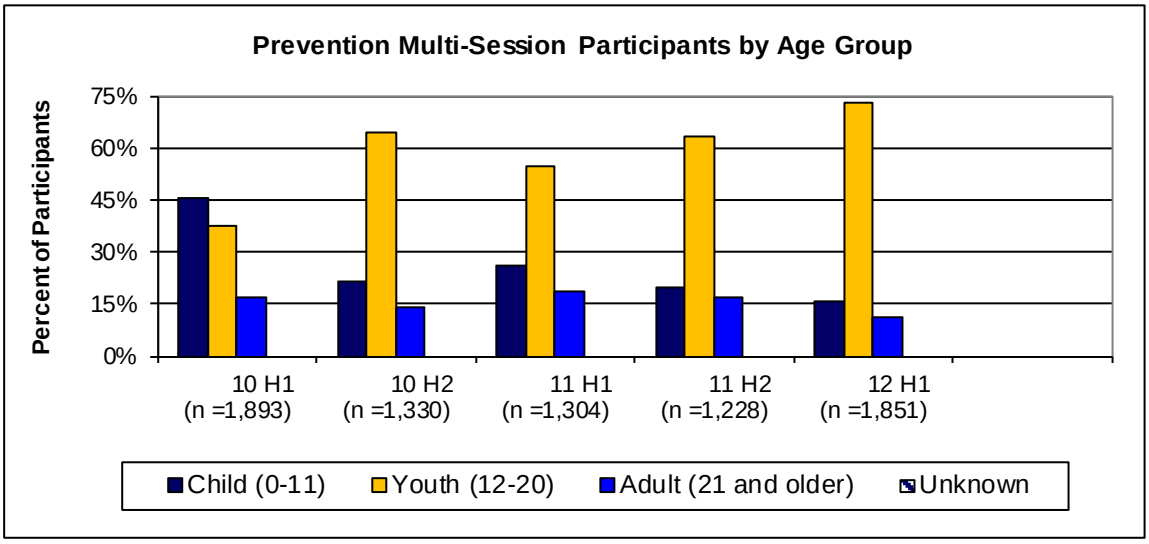
Risk and protective factors are addressed through single event or multi-session programs.

Single event programs during 2012 were:

- School/community-based events developed and sponsored by youth that targeted bonding reached 4,402 youth.
- Coalition events designed to decrease risk associated with low neighborhood attachment reached 541 community members (adult and youth).

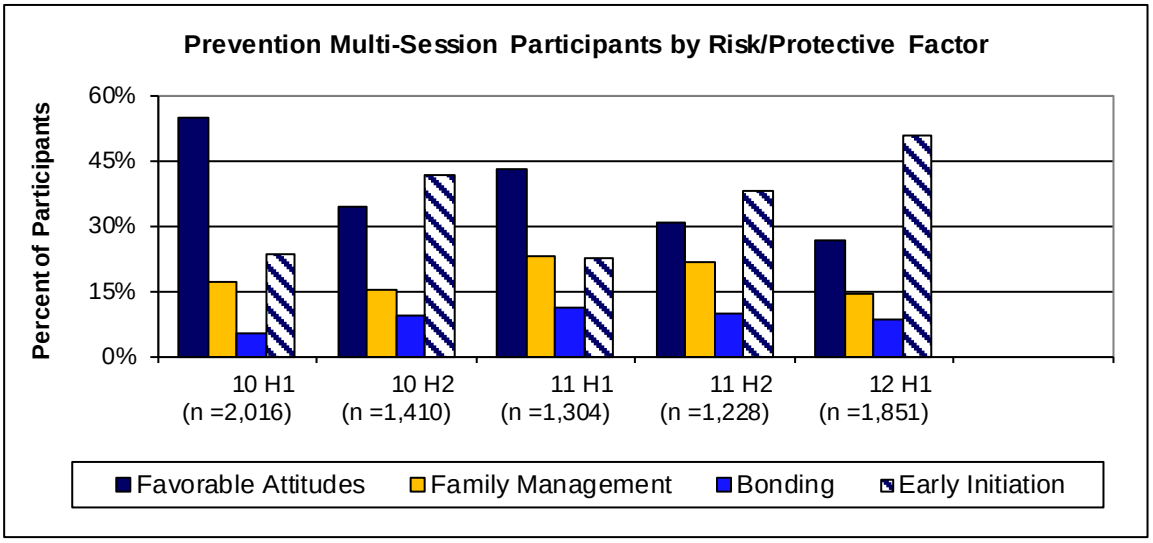
Prevention programs that have a multi-session format, such as skills training classes or support groups, collect demographic data about participants. Only multi-session programs are included in the following graphs.

The following graph shows the number of participants by biennial quarter and age group.



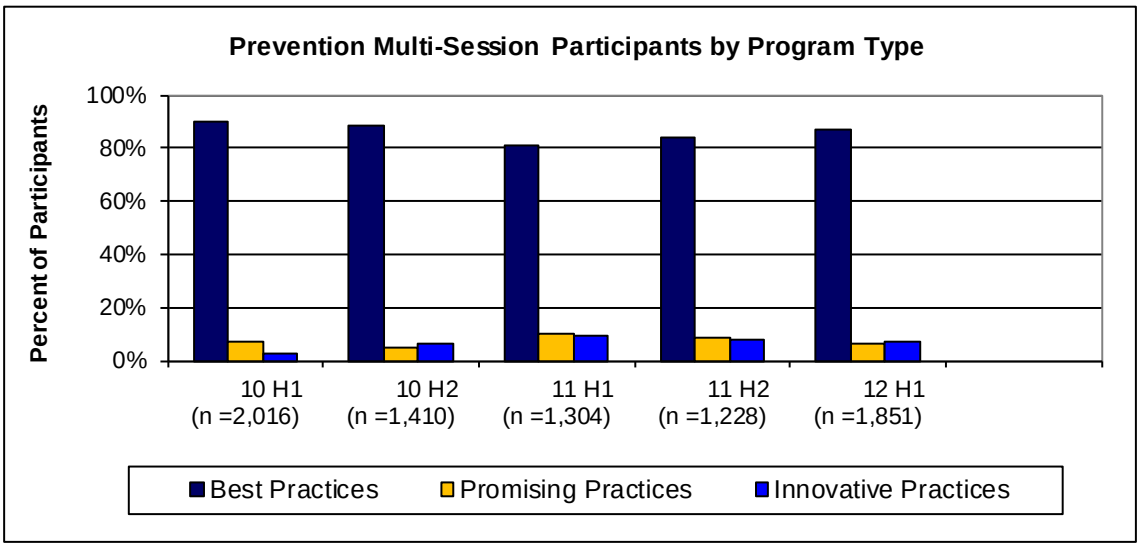
The large changes above in the relative proportions of the Child and Youth age groups reflect programs based on the school calendar as well as biennial changes in targeted risk/protective factors.

The following graph shows the number of participants by the risk or protective factor that is targeted by the program. Participants in more than one program during a quarter are counted for each one.



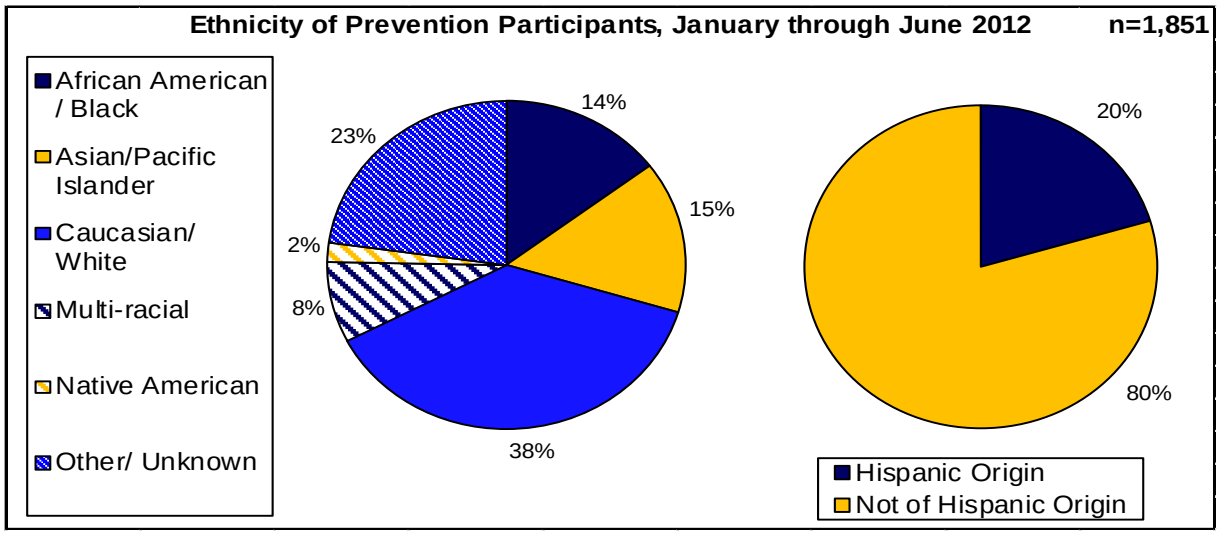
As with the age groups graph, the changes above in the percentages of risk factors result from biennial changes in the targeted factors and the fact that many prevention programs are scheduled in conjunction with the school calendar.

Research has validated the effectiveness of some prevention programs while others have not been evaluated yet. Applying this research, programs funded in King County are categorized as “best practices,” “promising practices,” or “innovative practices.” The following graph shows the number of participants by biennial quarter and program type. Participants in more than one program during a quarter are counted for each one.



The results above show continued focus on prevention methods that have been demonstrated to be effective. The biennial quarterly variation in participant numbers reflects programs based on the school calendar as well as differences in the mix of services during the time period.

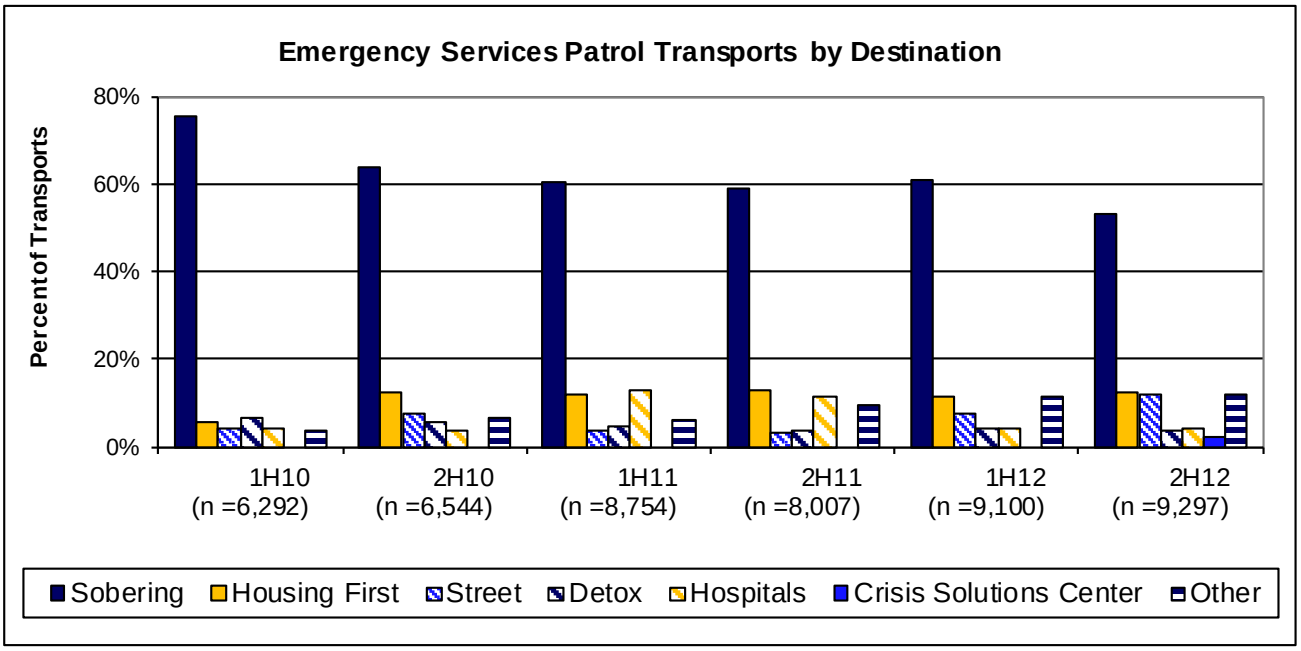
The charts below show the ethnicity of people who participated in multi-session prevention programs from July through December 2012.



Emergency Services Patrol

The main duty of the Emergency Services Patrol (ESP) screeners is to relieve firefighters, police and medics from caring for chronic users in need of non-emergency assistance. They do this primarily by transporting publicly inebriated individuals to the Dutch Shisler Service Center (DSSC), commonly known as The Sobering Center, or other safe environments. The screeners also patrol the downtown core, seeking out individuals in need of service. In addition, they transport clients away from the sobering service center to other service providers. The service operates 24 hours a day, 7 days a week, every day of the year.

The chart below shows the number of individuals transported and the destination of each transport by biennial quarter.



The decrease in the percentage of transports to the sobering service center over the quarters in this report reflects increased programming at DSSC designed to assist people into recovery support systems.

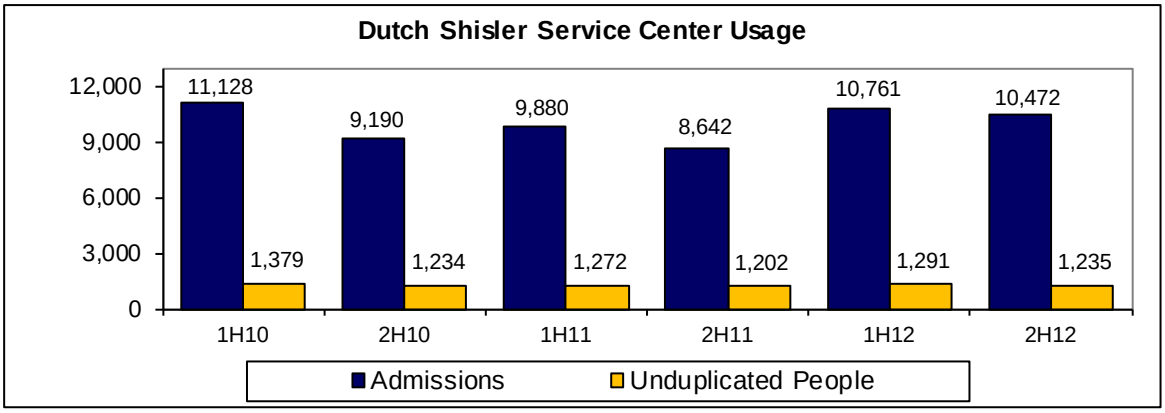
This report has a new transport category for the Crisis Solutions Center (CSC), which opened August 6, 2012. This new resource for first responders provides crisis diversion services as a therapeutic, community-based alternative to jail and hospital settings for individuals in behavioral health crisis. Upon request by CSC staff, individuals in crisis who have been referred by first responders and accepted for admission may be transported there by the ESP. This frees up first responders for other emergencies.

Client-specific demographic data about ESP services are not currently available. Until that data is available, the demographic data from DSSC provide a good approximation of ESP client demographics as a majority of transports are to that site.

Dutch Shisler Service Center (DSSC)

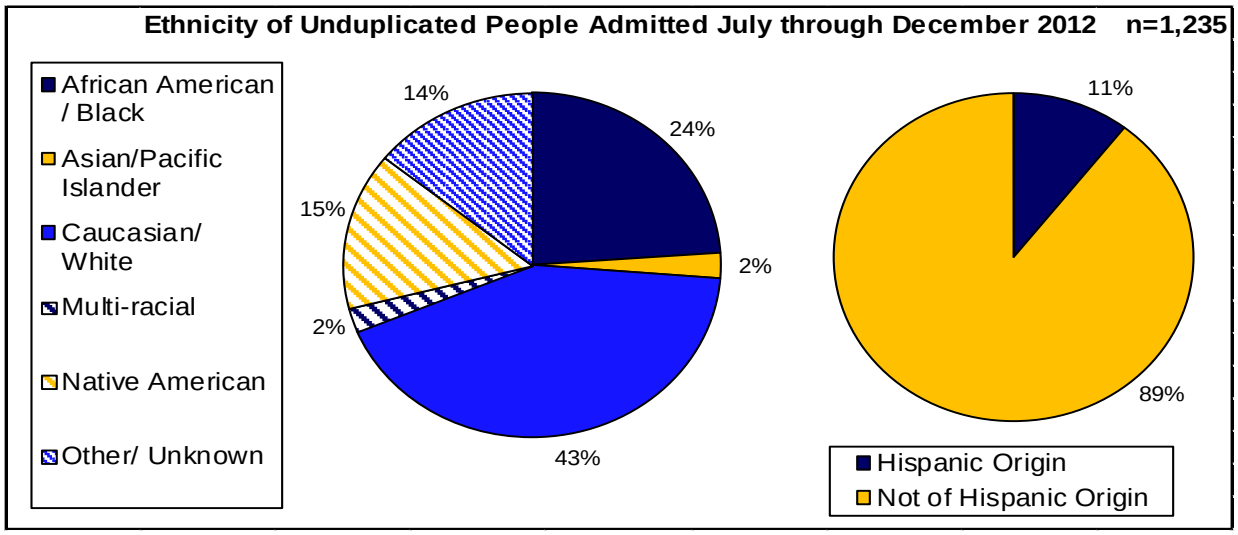
The Dutch Shisler Service Center serves as a safe and secure place for persons to sleep off the acute effects of intoxication and is an important recovery entry point in King County's recovery-oriented system of care. It serves as a center for clients to access case management services, outpatient chemical dependency treatment, and other assistance to move towards greater self-sufficiency.

The chart below shows the number of admissions to the Dutch Shisler Service Center for sobering services, and the number of unduplicated people who used that service.

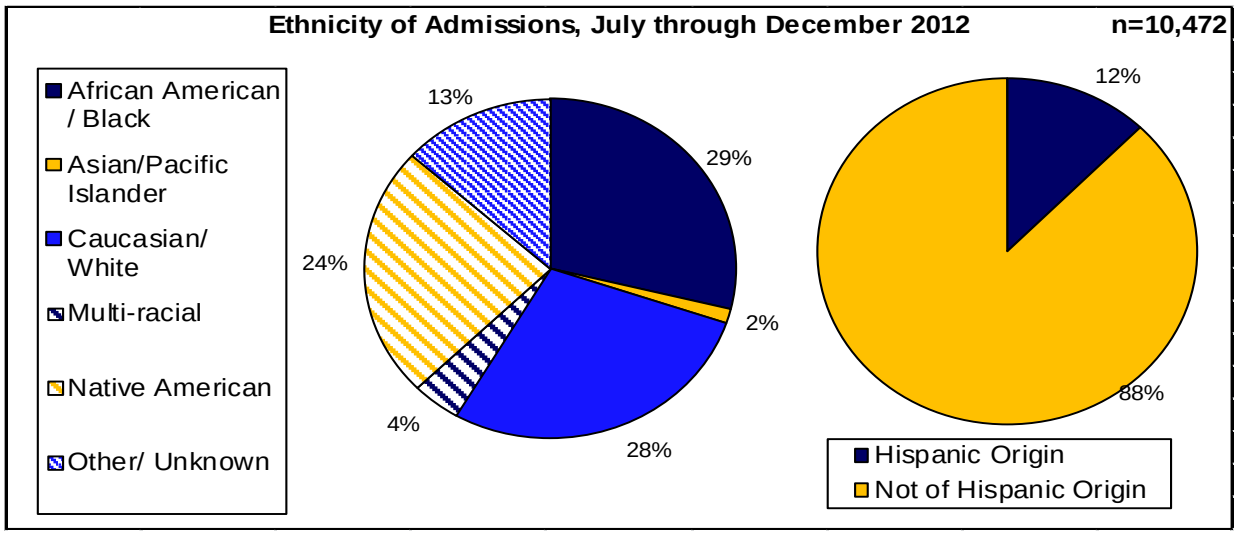


From the data above, it is clear that some individuals have multiple admissions to DSSC. In the last biennial quarter, 9.2 percent (114) of the 1,235 people admitted accounted for 63 percent of the total admissions. These 114 individuals averaged 58 admissions each during the six-month period, with a range from 25 to 216 admissions. Frequent users of the center are often involved in multiple systems, such as primary and behavioral health, social services, criminal justice, and housing. These individuals have complex and chronic needs and are generally not served effectively by the high-cost settings, such as emergency departments, they tend to access.

The following charts show the ethnicity of unduplicated people served by DSSC from July through December 2012. See Appendix A for additional details.



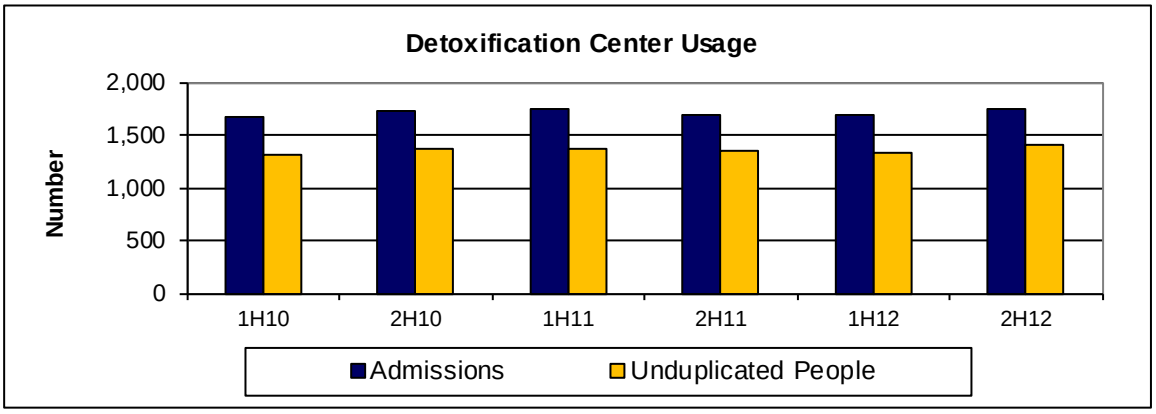
Among those admitted to DSSC during July through December 2012, the percentage who are Native American (15 percent) is much higher than the percentage of Native Americans in either the general population (two percent) or in any other drug/alcohol program area (see Summary Data, Demographic Detail). In addition, a disproportionate number of the frequent users of DSSC are Native American: 21 percent of those admitted five times or more in the last biennial quarter were Native American. As shown in the chart on the left below, 24 percent of all admissions to DSSC in the last biennial quarter are for Native Americans although Native Americans are only 15 percent of the unduplicated individuals served, as shown in the chart on the left above.



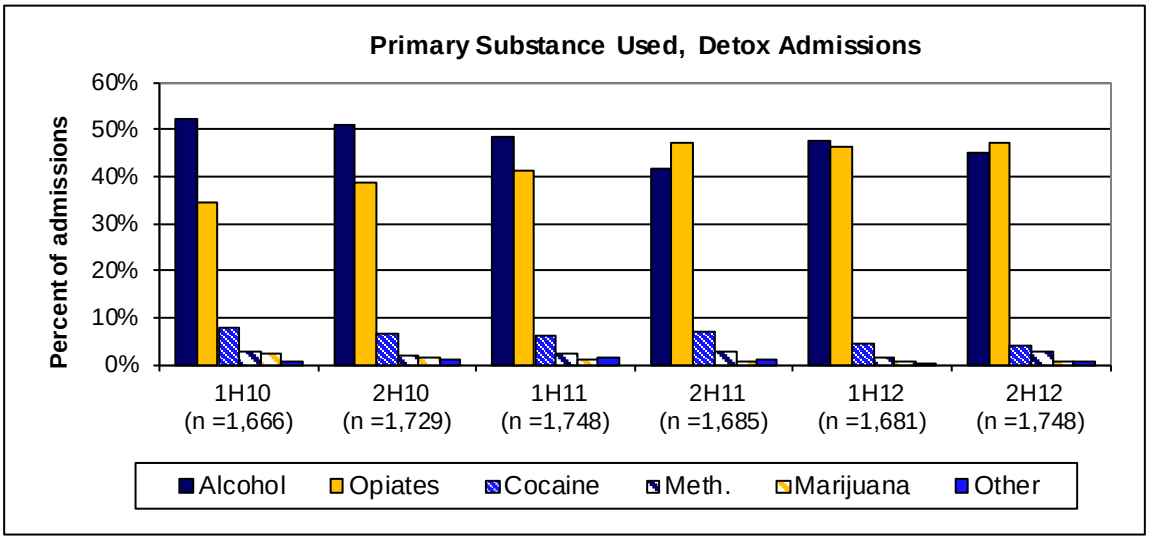
Detoxification Center

Detoxification services are provided to indigent clients who are withdrawing from alcohol or other drugs. Upon successful completion of detoxification services, clients are referred for ongoing treatment and support.

The chart below shows the number of new admissions to the Detoxification Center during each biennial quarter and the number of unduplicated people admitted.



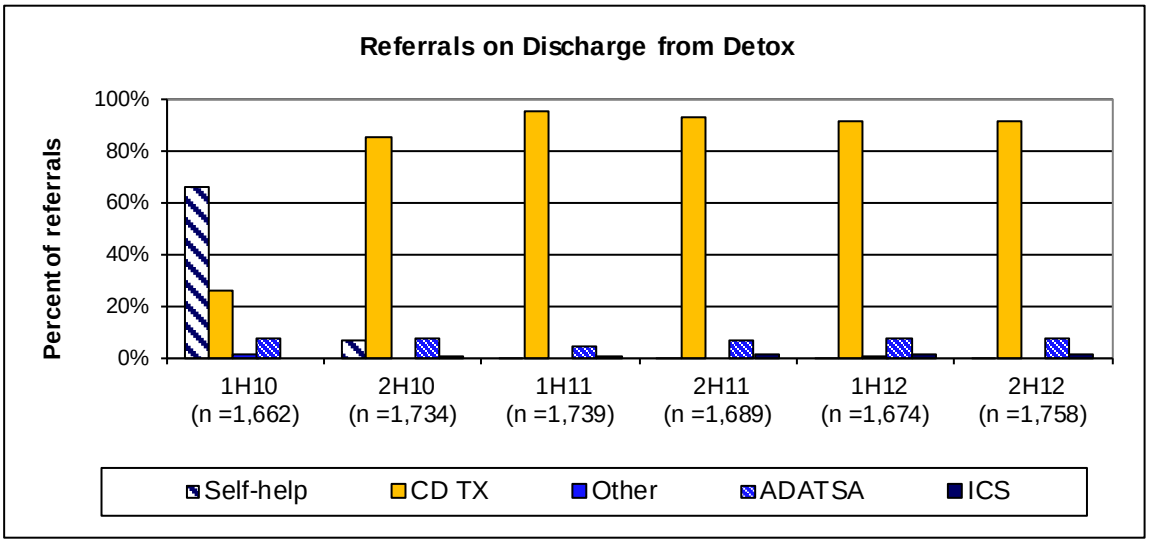
The following chart shows the primary substance used by people admitted to the Detoxification Center. This is usually, but not always, the substance for which detoxification is needed (see Appendix A for more information).



There was a steady increase over the six biennial quarters from 2009 (not shown) through 2011 in the percentage of Detoxification clients who indicate opiates as their primary drug used. That increase leveled off in 2012. Alcohol went from being the primary substance used for 62 percent of admissions in the first half of 2009 to only 45 percent of admissions in the second half of 2012. The second biennial quarter of 2011 was the first time that opiates surpassed alcohol as the primary drug reported upon admission to detoxification services. This trend in admission data is consistent with epidemiological trends statewide and nationally, showing a rise in opiate use.

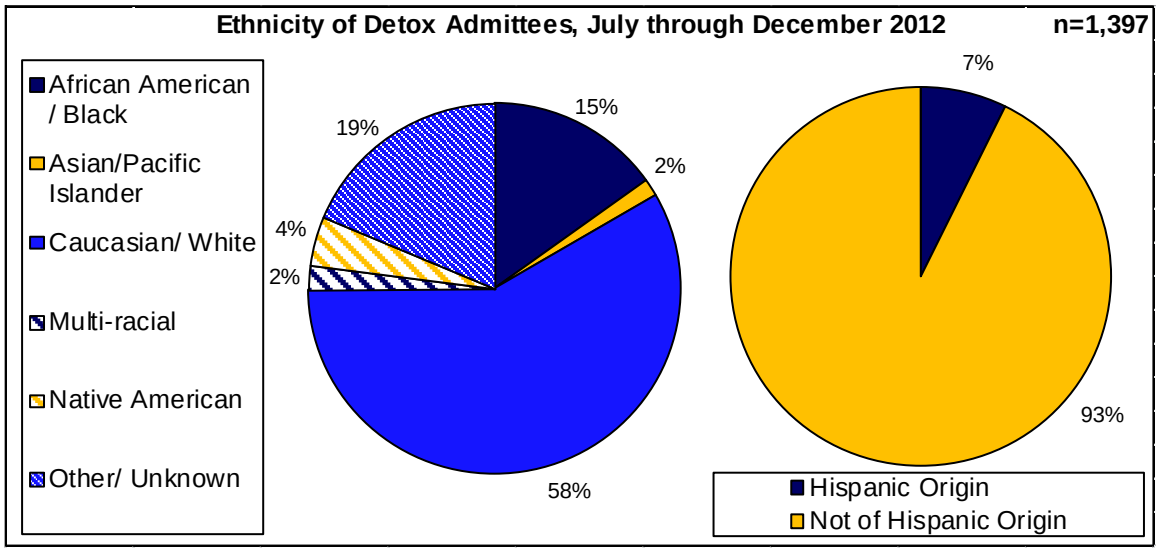
From the first half of 2008 through the second half of 2011, there was also a steady increase in the number and percentage of young adults under 30 years old entering detoxification services. Among all individuals admitted from 2009 through 2012, 75 percent of those under 30 years old indicated opiates are their primary drug used compared to 28 percent of those 30 years or older. See the "Program Comparisons" section for more discussion of these changes.

The chart below shows the resources to which people were referred when discharged from the Detoxification Center, based on the biennial quarter of the discharge. A person leaving detoxification who received referrals to different kinds of resources is counted once based on a hierarchy of resources that ranks treatment higher than self-help groups. See Appendix A for more information.



The dramatic increase in referrals to treatment during 2010 is the result of more accurate data reporting and does not indicate a change in the actual referral practices at the Detoxification Center.

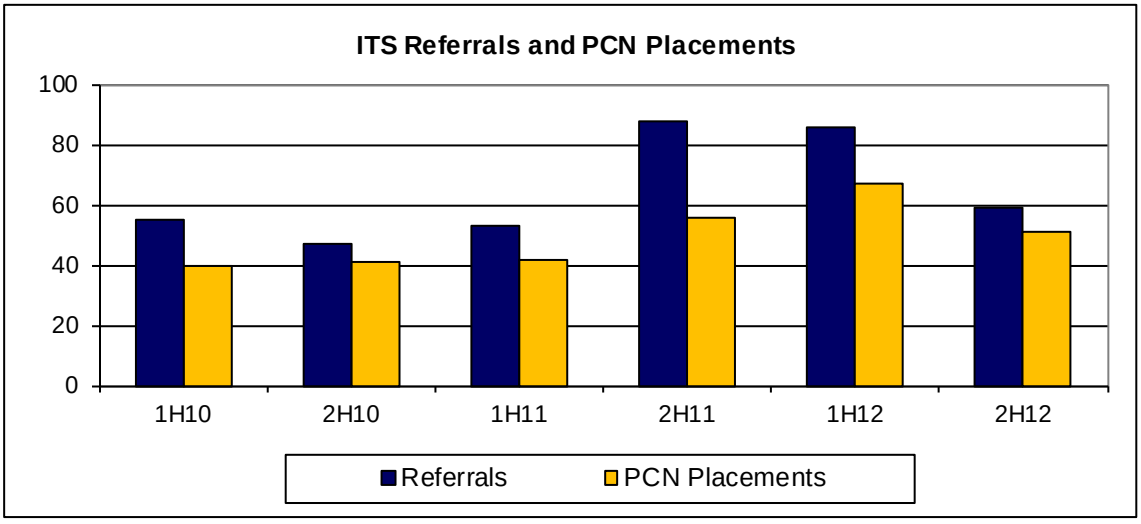
The charts below show the ethnicity of unduplicated people admitted to the Detoxification Center from July through December 2012. See Appendix A for additional details.



Involuntary Commitment Services

Involuntary Commitment Services (ICS) include investigation and evaluation of facts to determine whether a person is incapacitated as a result of chemical dependency. If a chemical dependency specialist determines there is reliable evidence to support a finding of incapacity, a petition for commitment can be filed on behalf of the incapacitated person. Courts can then commit a person to a locked treatment facility for intensive treatment.

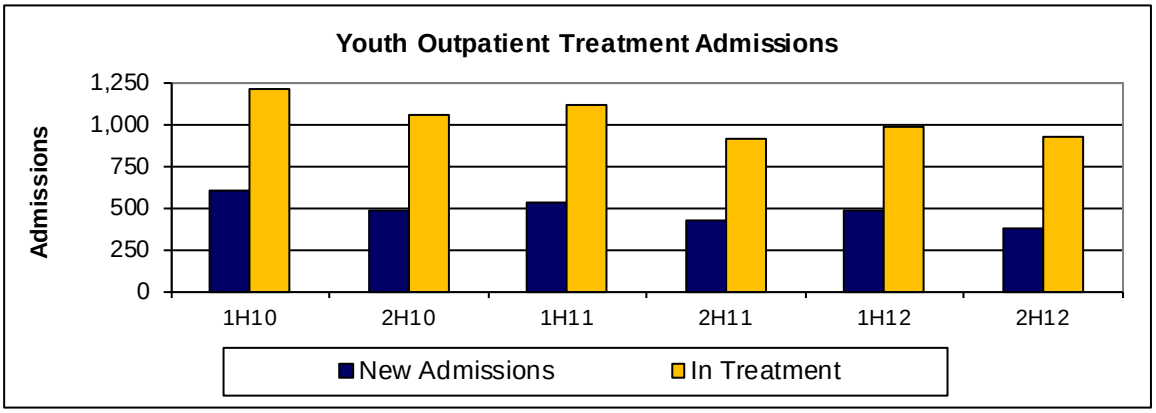
The following chart shows the referrals received by ICS for investigation and the number of commitments that resulted in a placement at Pioneer Center North (PCN) for inpatient treatment.



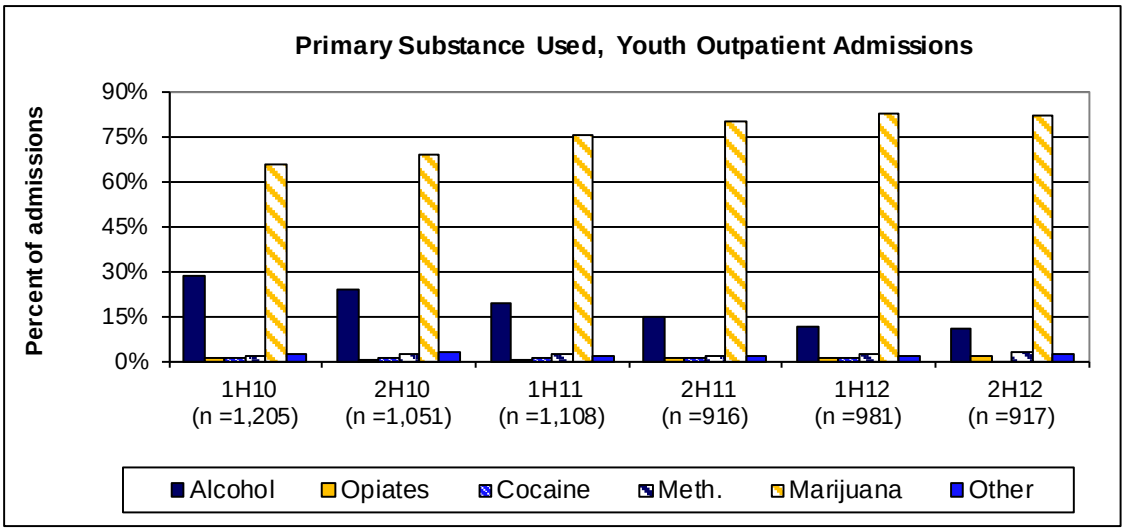
Outpatient Treatment – Youth

Outpatient treatment services for youth are targeted for low-income and indigent youth who are abusing or who are chemically dependent on alcohol and other substances. Services include development of sobriety maintenance skills, family therapy or support, case management and relapse prevention. Services are expected to improve school performance and peer and family relationships, prevent or reduce criminal justice involvement, and to decrease risk factors associated with substance use and abuse.

The following chart shows existing caseloads plus new admissions to outpatient treatment for youth under 18 years old. Both "new admissions," which started during the biennial quarter, and "in treatment" are shown. "In treatment" includes anyone who was admitted at any time and not yet discharged by the start of the quarter.



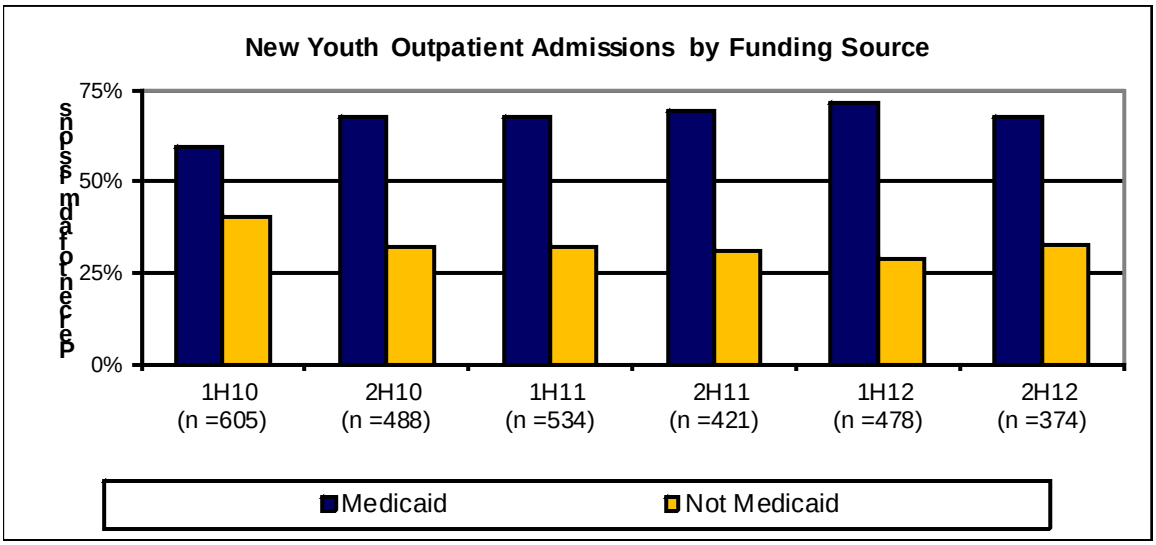
The following chart shows the primary substance used by youth in outpatient treatment.



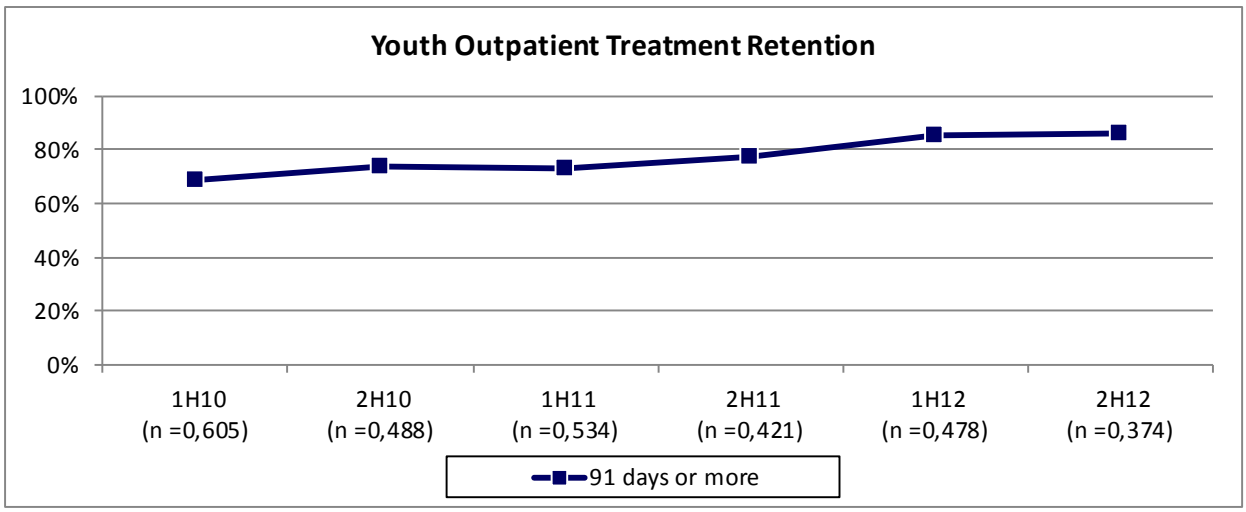
While the most frequently used drug among youth in treatment is marijuana, a significant percentage of youth are using alcohol. The difference in proportion for those admitted to treatment for marijuana

versus alcohol continues to grow, with marijuana increasing and alcohol decreasing as the primary substance used. Very few youth are in treatment for opiate use, which appears to become more problematic for people in their twenties.

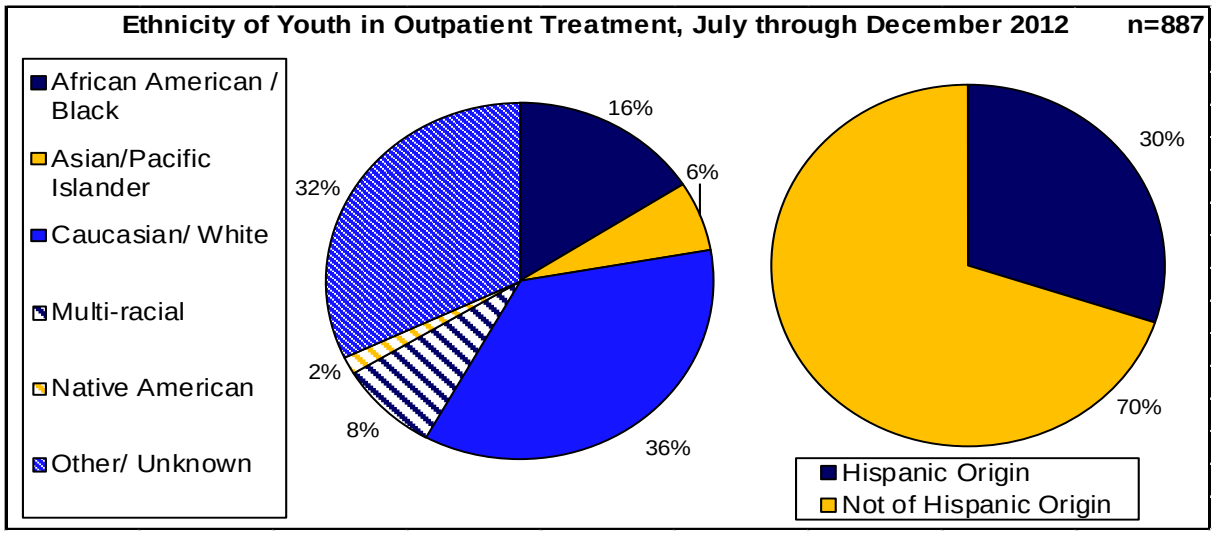
The chart below shows the proportion of newly admitted youth each biennial quarter whose treatment is funded by Medicaid versus other public funding.



In mid-2011, the Washington State Division of Behavioral Health and Recovery (DBHR) dropped a long-standing focus on treatment completion as a key outcome measure and shifted focus to treatment retention starting in 2012. Because research shows that people who remain in treatment for more than 90 days tend to have better outcomes, this report includes a new measure of those who started treatment during each report period and remained in treatment for 91 days or longer. (See Appendix A for details on how the rate is determined.)



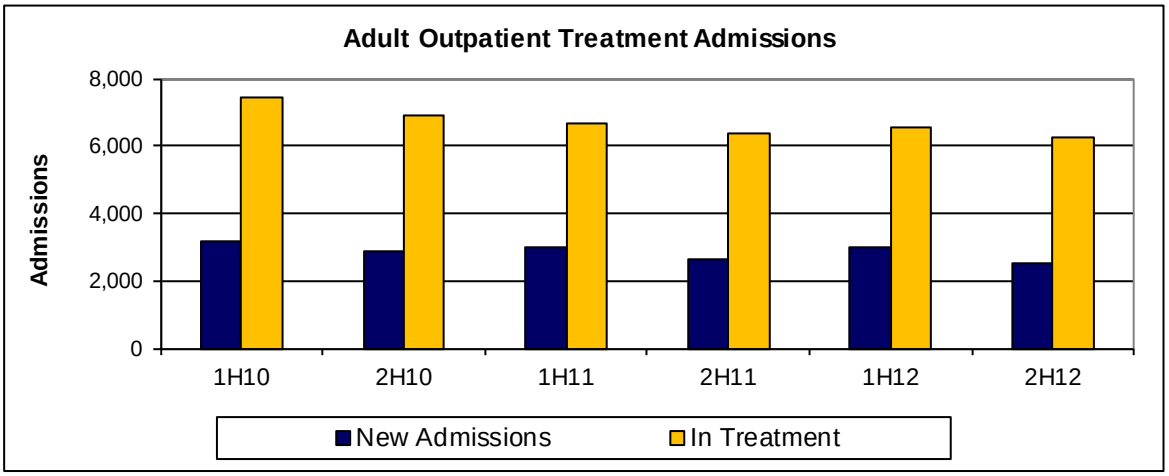
The charts below show the ethnicity of unduplicated youth receiving outpatient treatment from July through December 2012. See Appendix A for additional details.



Outpatient Treatment – Adult

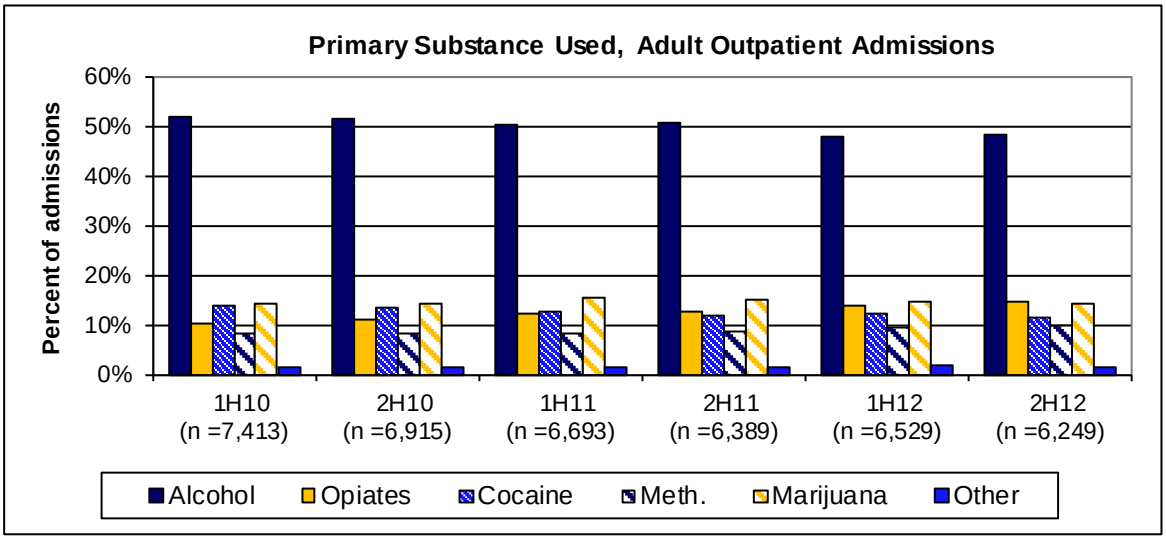
Outpatient treatment services provide treatment to low-income and indigent adults, 18 years and older, who need treatment to recover from addiction to drugs and/or alcohol. Services are designed to assist clients with achieving and maintaining sobriety, and can include individual face-to-face treatment sessions, group treatment, case management, employment support, or other services, including referrals to appropriate agencies.

The following chart shows caseloads and admissions to outpatient treatment for adults, 18 years and older. Both "new admissions," which started during the biennial quarter, and "in treatment" are shown. "In treatment" includes anyone who was admitted at any time and not yet discharged by the start of the quarter.



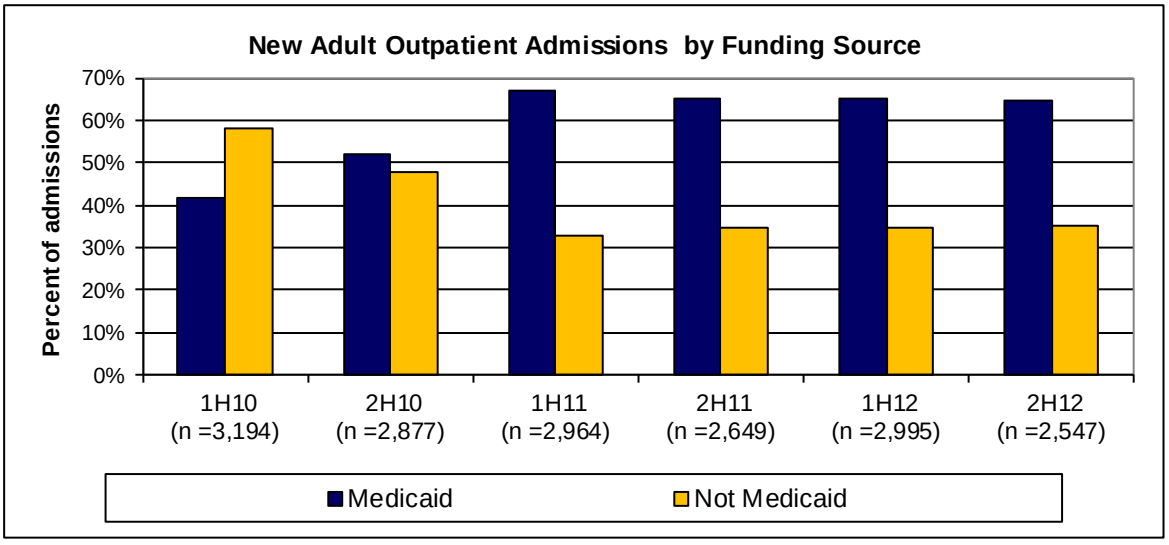
The decreases from 2010 through 2011 in the number of people remaining in treatment reflect decreased state funding available for outpatient treatment for those who do not have Medicaid coverage.

The following chart shows the primary substance used by adults in outpatient treatment.



Although the total number of adults in treatment decreased 11 percent between 2010 and 2012, the number in treatment where the primary substance used was opiates increased by 20 percent. Across the quarters in this report, there was a fairly steady increase in the percentage with opiates as the primary substance, from 10 percent in the first quarter of 2010 to 15 percent in the second quarter of 2012. Alcohol remained by far the most frequently reported primary substance used, although it is decreasing in relation to the proportion of those reporting opiates as their primary substance.

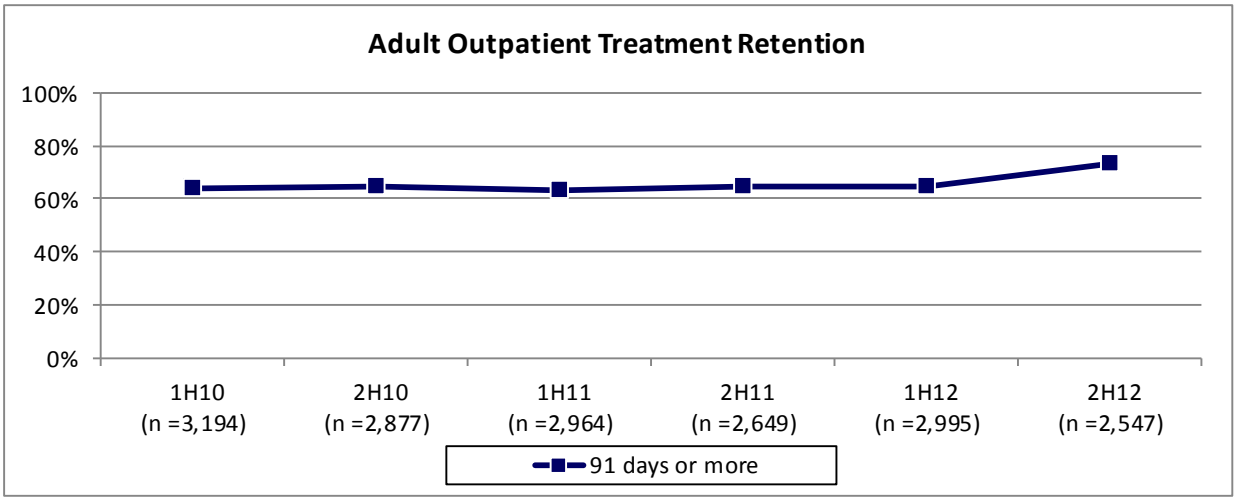
The following chart shows the proportion of newly admitted adults each biennial quarter whose treatment is funded by Medicaid versus other public funding.



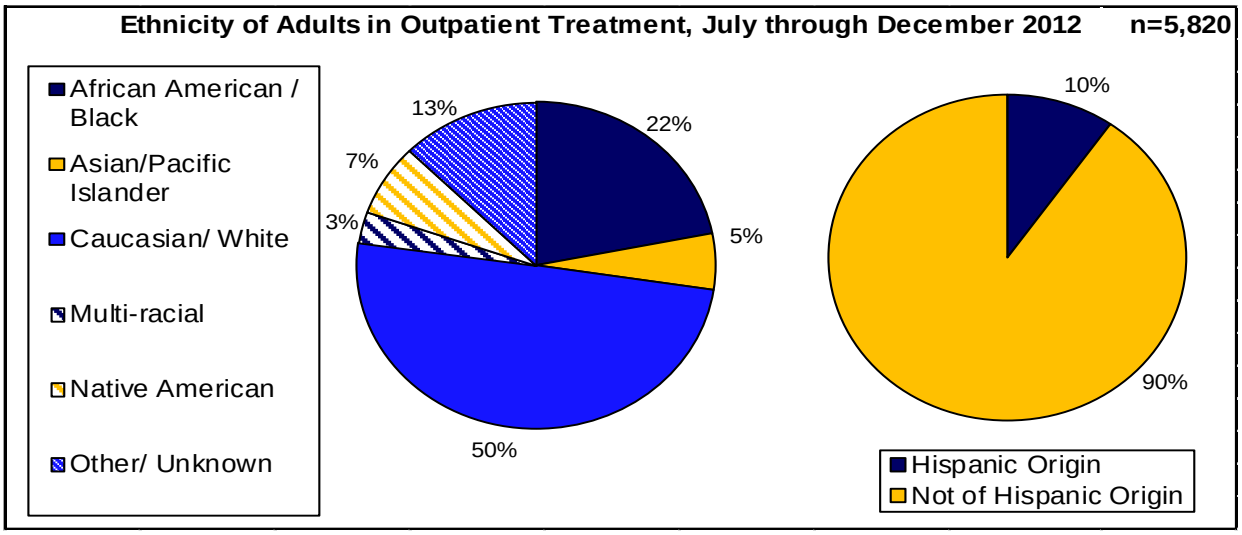
The impact of dramatic reductions in state non-Medicaid funding for adult outpatient treatment is evident in the large decrease in the percentage of non-Medicaid funded admissions from the first half of 2010 to the first half of 2011. The number of people admitted to treatment with non-Medicaid funding declined 51 percent from the first half of 2010 to the second half of 2012, which was only partially offset

by a 23 percent increase in the number of adults with Medicaid coverage who were admitted to treatment during the same period.

In mid-2011, DBHR dropped a long-standing focus on treatment completion as a key outcome measure and shifted focus to treatment retention in 2012. Because research shows that people who remain in treatment for more than 90 days tend to have better outcomes, this report includes a new measure of those who started treatment during each report period and remained in treatment for 91 days or longer. (See Appendix A for details on how the rate is determined.)



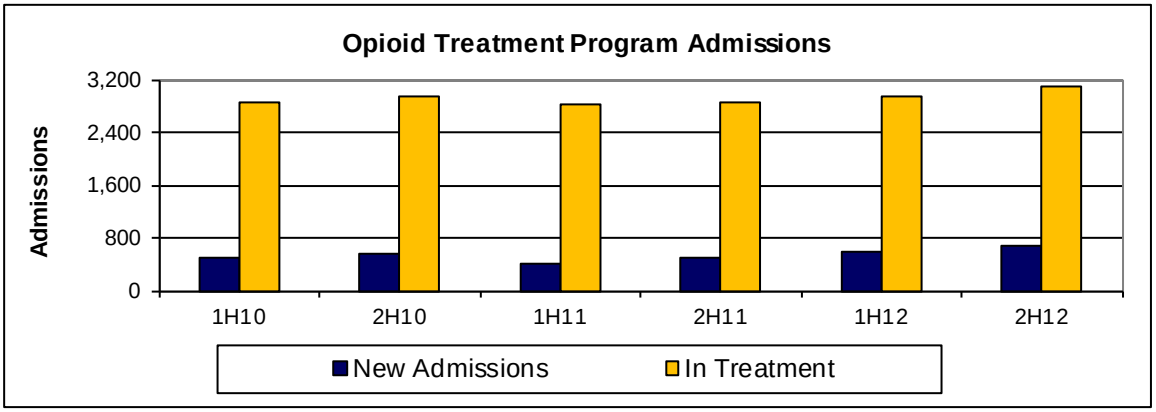
The charts below show the ethnicity of unduplicated adults receiving outpatient treatment from July through December 2012. See Appendix A for additional details.



Opioid Treatment Programs

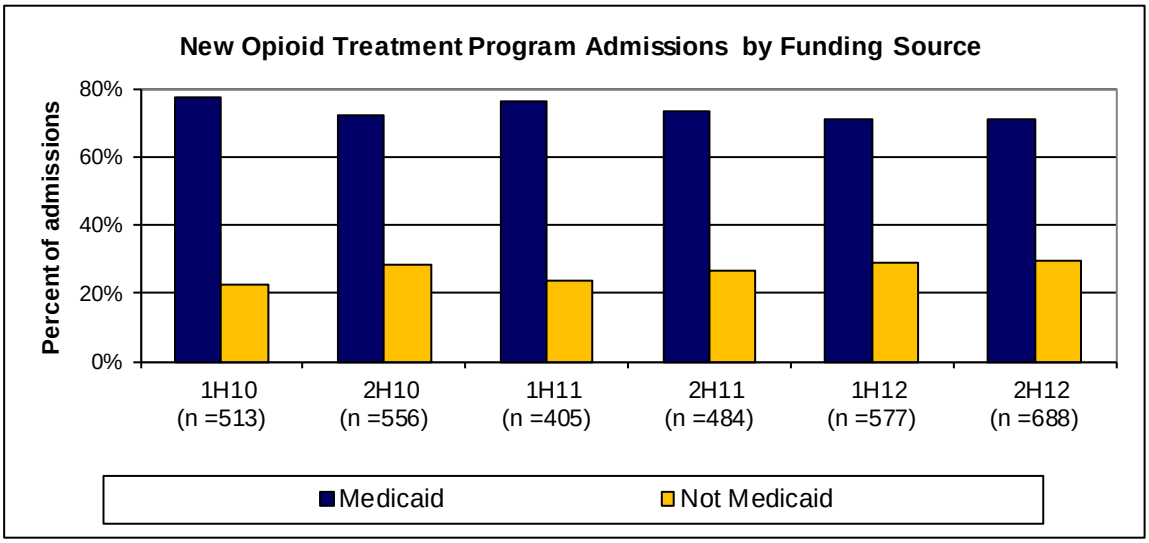
Opioid treatment programs (OTP) provide medically supervised medication-assisted treatment services to individuals addicted to opiates, whether to heroin or prescription opiates. In addition to physical exams and medical monitoring, clinics provide individual and group counseling, medications, urinalysis screening, referral to other health and social services, and patient monitoring.

The chart below shows caseloads and admissions to opioid treatment programs. Both "new admissions," which started during the biennial quarter, and "in treatment" are shown. "In treatment" includes anyone who was admitted at any time and not yet discharged by the start of the quarter.

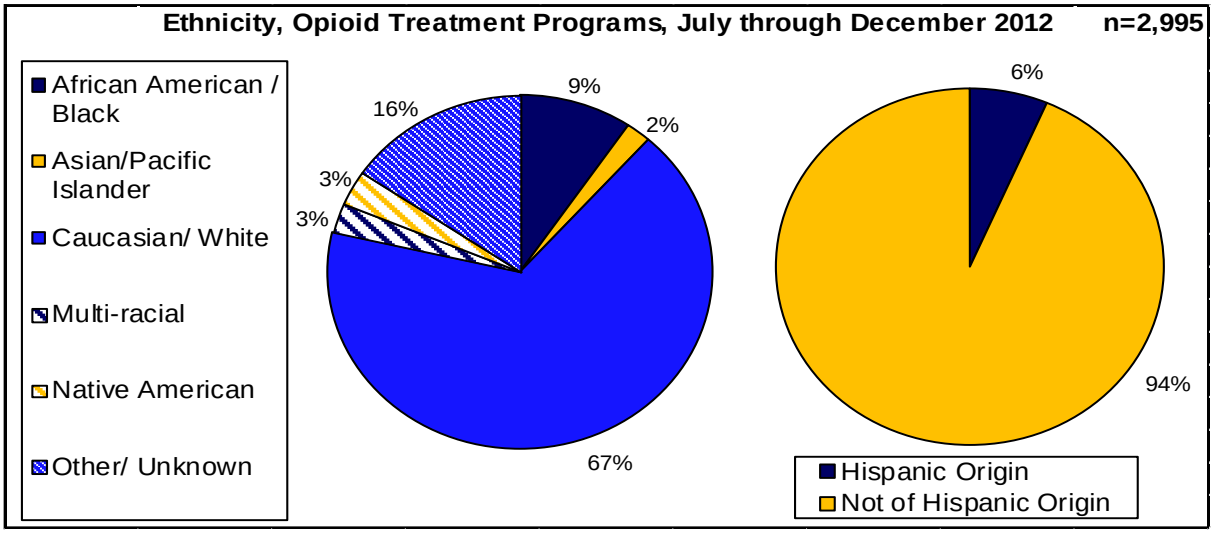


Consistent with the goals of this treatment modality, individuals tend to be retained in medication-assisted treatment for long durations, limiting the availability of new treatment slots. The increase in both new admissions and people in treatment during the second half of 2012 reflects increased treatment capacity from the new OTP clinic that opened in Bellevue in July 2012. The OTP waitlist went from 286 at the end of June 2012 to 212 at the end of December 2012. The County is working with treatment providers to open another new clinic in South King County to continue to address limited capacity and countywide services (see King County Opiate Treatment Expansion, p.27). Trends in treatment admissions are a function of funding availability and not demand.

The following chart shows the proportion of newly admitted people each biennial quarter whose opioid treatment is funded by Medicaid versus other public funding.



The following charts show unduplicated people receiving opioid treatment from July through December 2012. See Appendix A for additional details.



Summary Data

Overview

This section provides summary data for the current calendar year on services provided, dispositions and demographics of individuals served. It also provides summary data for the last three calendar years for financial revenues and expenditures.

The services data are for the same program areas and measures that were presented graphically in the Programs section. The time period that the data describe is different. Data in this section are for the most recent calendar year, which is the same time period as the last two biennial quarters shown in the charts. See Appendix A for additional details.

The demographic data are broader than the data in the Programs section. The gender, race or ethnic group and Hispanic origin status of all unduplicated individuals served during the most recent calendar year are reported. This includes all programs except the Emergency Services Patrol.

To provide context, U.S. Census Bureau data for gender and ethnicity in the youth and adult populations in King County that are below the federal poverty level are shown in addition to the demographic data for each program. Although many people with somewhat higher incomes also qualify for public funding, these data approximate the gender and ethnic mixtures among King County residents who are eligible for publicly funded services. Data for the "Youth Outpatient" programs should be compared to the "Youth" population. All other programs except Prevention serve only adults. (Data Source: U.S. Census Bureau, 2005-2009, American Community Survey, B17001A-I tables.)

The financial data (see page 56) include a financial plan for actuals for 2010, 2011 and 2012, and the expenditures for outpatient treatment services. The financial plan shows the beginning fund balance, revenues received by revenue type, expenditures made by expenditure, and the ending fund balance. The financial plan does not include dollars from the Mental Illness and Drug Dependency (MIDD) Action Plan. The chart at the bottom of the page combines the contracted expenditures for outpatient treatment services from the financial plan with the MIDD expenditures. The chart is broken out by outpatient treatment services for adults and youth, and opioid treatment programs. Total contracted outpatient services accounted for $17,021,862 in 2010, $16,707,296 in 2011, and $17,659,026 in 2012.

Title XIX (Medicaid) dollars are not included in the financial plan figures. Title XIX dollars combine state and federal funds to pay for treatment services. Money is set aside from the MHCADSD biennium contract with the State and allocated to chemical dependency treatment agencies to provide treatment services. These dollars are then matched with federal dollars and disbursed by the state directly to agencies for treatment services provided to Medicaid recipients. For 2012, the Title XIX County Billing Detail Reports provided by DBHR and agency reports as recorded in the MHCADSD Invoice Processing System show that $10,571,706 was billed by agencies with $9,194,462 paid to agencies. This is a decrease from the amount paid to agencies in 2011 of $369,914 or 4.0 percent.

Services and Dispositions, January – December 2012

	Number	Percent
Prevention Participants	1,851	100%
Age Group		
Child	288	16%
Youth	1,355	73%
Adult	208	11%
Unknown	0	0%
Risk/Protective Factor		
Favorable Attitudes	494	27%
Family Management	265	14%
Bonding	155	8%
Early Initiation	937	51%
Program Type		
Best Practices	1,615	87%
Promising Practices	111	6%
Innovative Practices	125	7%
ESP Transports		
All Destinations	18,397	100%
Sobering	10,490	57%
Housing First	2,195	12%
Street	1,821	10%
Detox	727	4%
Hospitals	757	4%
Crisis Solutions Center	223	1%
Other	2,184	12%
Sobering Center		
Admissions	21,233	
Unduplicated People	2,031	
Detoxification Center		
Admissions	3,429	
Unduplicated People	2,452	
Admissions by drug of choice	3,429	100%
Alcohol	1,585	46%
Opiates	1,602	47%
Cocaine	142	4%
Methamphetamines	71	2%
Marijuana	17	0%
Other	12	0%
Referrals on discharge, all d/c	3,433	100%
Self-help	7	0%
CD TX	3,121	91%
Other	1	0%
ADATSA	261	8%
ICS	43	1%
Housing	0	0%

	Number	Percent
Involuntary Commitment Services		
Referrals	145	
Unduplicated people	140	
PCN Placements	118	
Outpatient Treatment		
Youth		
New admissions	852	
In Treatment	1,355	
Unduplicated people (open)	1,274	
Open admissions by drug of choice		
Alcohol	158	12%
Opiates	19	1%
Cocaine	8	1%
Methamphetamines	34	3%
Marijuana	1,107	82%
Other	29	2%
New admissions by Medicaid status		
Medicaid	594	70%
Not Medicaid	258	30%
Treatment retention for admissions during year		
91 days or more	730	86%
Less than 91 days	122	14%
Adult		
New admissions	5,542	
In Treatment	9,076	
Unduplicated people (open)	7,911	
Open admissions by drug of choice		
Alcohol	4,314	48%
Opiates	1,352	15%
Cocaine	1,040	11%
Methamphetamines	893	10%
Marijuana	1,320	15%
Other	157	2%
New admissions by Medicaid status		
Medicaid	3,603	65%
Not Medicaid	1,939	35%
Treatment retention for admissions during year		
91 days or more	3,805	69%
Less than 91 days	1,737	31%
Opioid Treatment Programs		
New admissions	1,265	
In Treatment	3,621	
Unduplicated people (open)	3,346	
New admissions by Medicaid status		
Medicaid	897	71%
Not Medicaid	368	29%

Program Comparisons

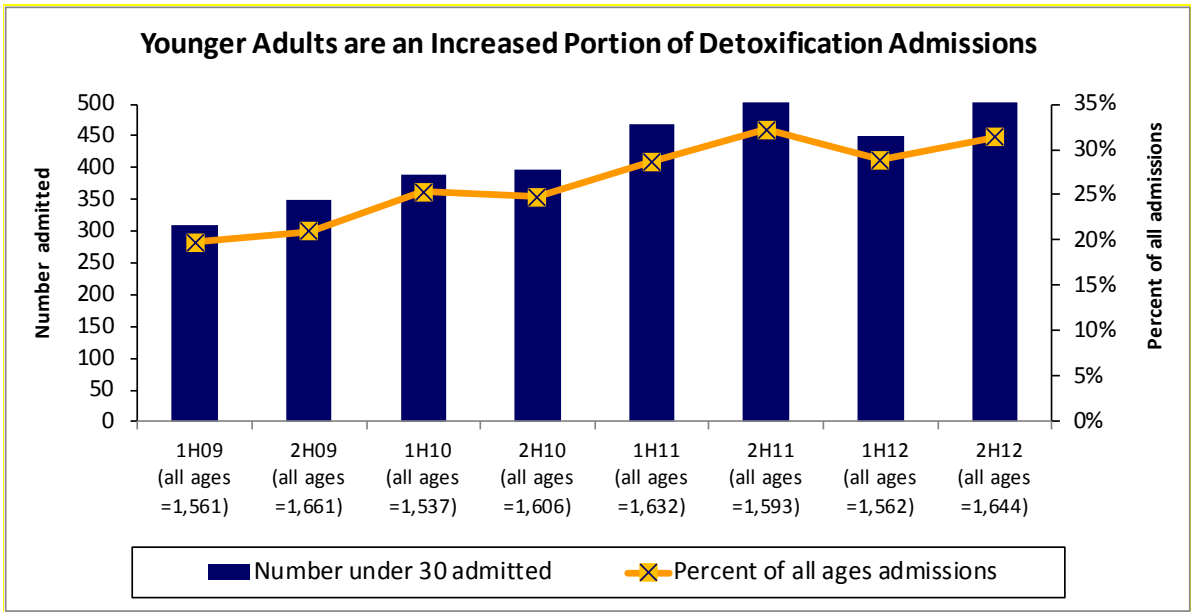
The table below shows data for the primary substance used by people admitted to different program areas and highlights differences among substances used.

Comparison of Primary Substance Used, January - December 2012

	Detoxification Center Admissions*	Outpatient Youth Admissions	Outpatient Adult Admissions
Total Number	3,429	1,355	9,076
Drug of Choice Percentage			
Alcohol	46%	12%	48%
Opiates	47%	1%	15%
Cocaine	4%	1%	11%
Methamphetamines	2%	3%	10%
Marijuana	0%	82%	15%
Other	0%	2%	2%

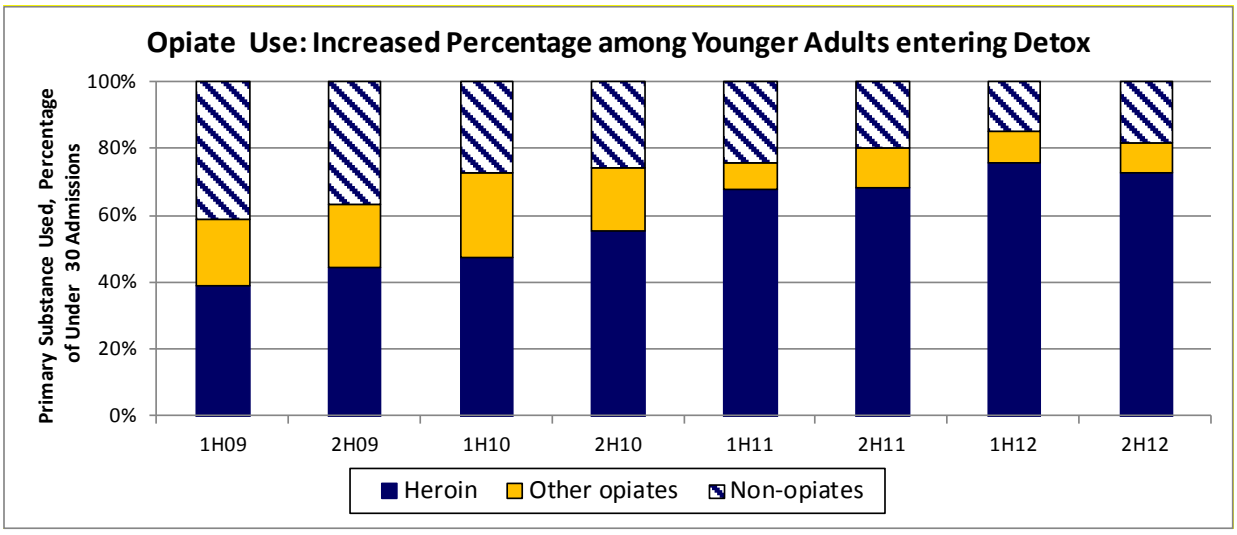
There is a dramatic difference between the Youth and Adult Outpatient identification of marijuana as the primary substance used.

As noted earlier, the percentage of people admitted for detoxification whose primary substance used is an opiate increased from 2009 through 2011 before leveling off in 2012, and the percentage using alcohol declined from 2009 through 2011. The change from 2009 through 2011 was driven by two factors shown in the following charts that also did not increase in 2012: an increase in the number and percentage of young adults under 30 years old entering detoxification services, and higher percentages of heroin or other opiate use among these detoxing young adults.

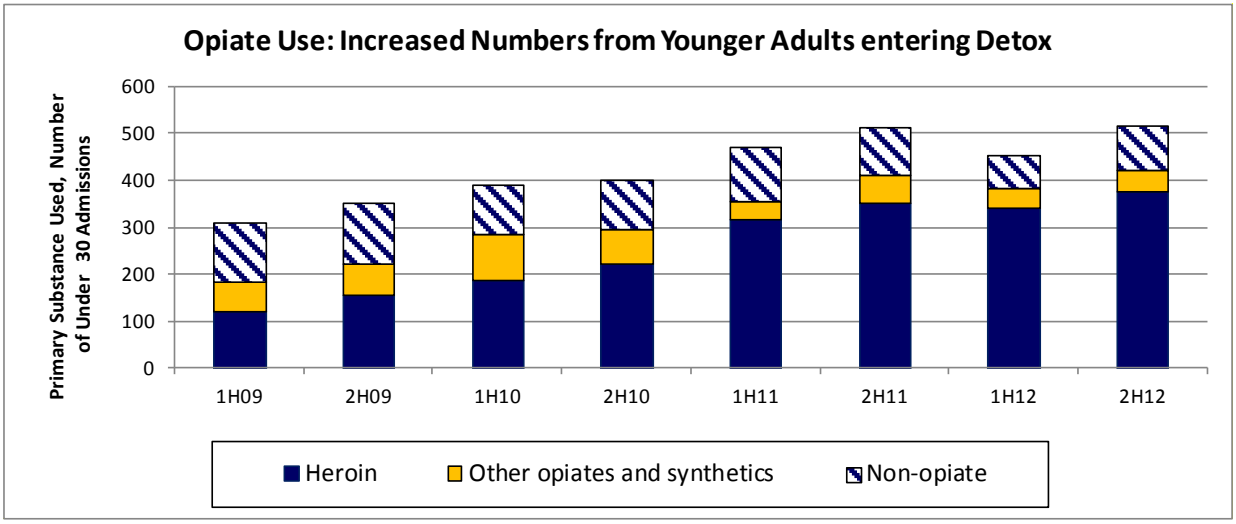


Because the total number of detoxification admissions each biennial quarter stays fairly constant, the number and percentage of young adults above had very similar increases across the four years from 2009 through 2012.

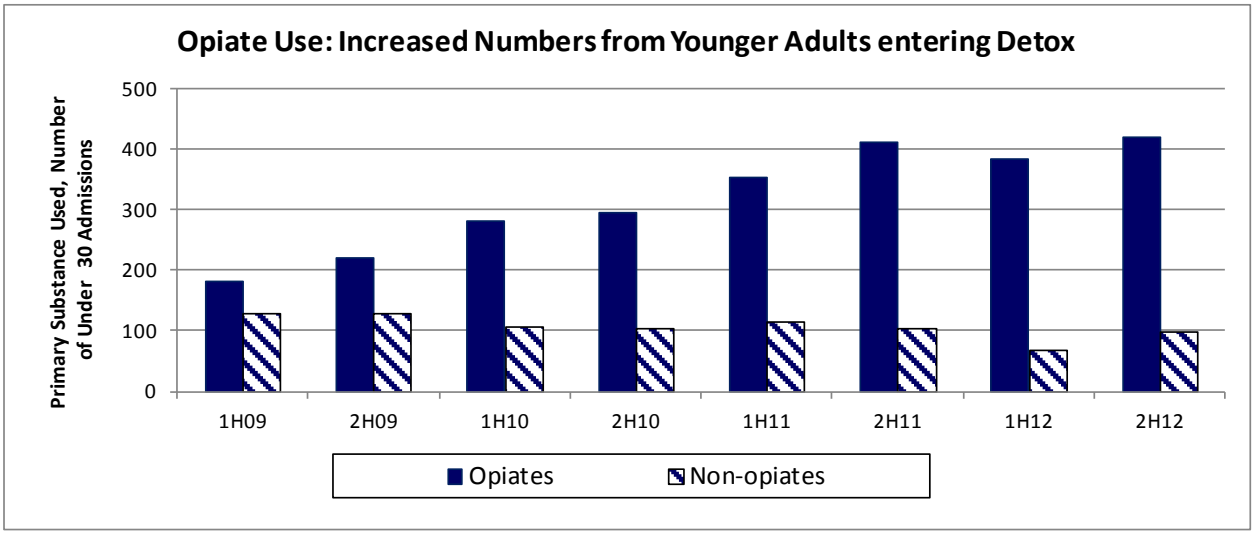
The following chart shows that, within the increased number of young adults seeking detoxification, a larger percentage is using opiates, with a more recent rise in heroin versus prescription opiates.



The following chart illustrates the compounded impact on the number of detoxification clients using opiates that has resulted from the increased percentage of younger adults in detoxification (first chart above) who are also more likely to use opiates (second chart above).



Here is another way to look at the impact of all opiate use by younger adults on detoxification admissions.



Although not as striking as the changes seen above in the use of opiates by those starting detoxification, there has been a small, steady increase over this three year report period in the use of opiates by adults in outpatient treatment (see the Adult Outpatient Treatment section). There has not been a clear increase in younger adults entering opioid treatment programs despite the significant increase in detoxing younger adults and opiate use within that group: the percentage of those under 30 years old who were admitted to an OTP in the last four years has varied between 26 and 29 percent with no sustained trend. It may be that some of these younger adults are accessing doctor's office-based treatment using buprenorphine and/or naltrexone or that some are opting to attempt traditional outpatient "drug-free" treatment rather than medication-assisted treatment.

The opiate use data above are consistent with the "Seattle-King County Drug Trends 2010" report from the University of Washington, Alcohol and Drug Institute, which indicates that prescription opiate abuse has been on the rise in King County until recently, particularly among young adults, and that non-heroin/non-morphine opiates have been the leading cause of drug-related death in King County since 2005, and surpassed traffic fatalities as a cause of death in Washington State in 2008. The most recent data shows a rise in heroin use and a dip in prescription opiate use.

Demographic Detail, January – December 2012

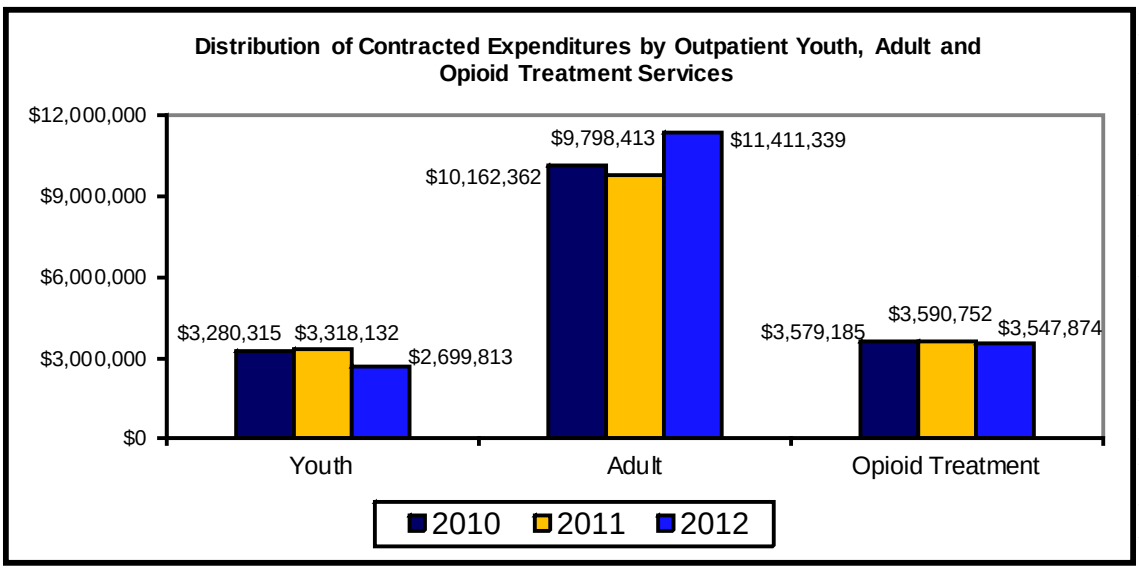
					Outpatient			King County Residents Below Fed. Pov. Level	
	Prevention	Sobering	Detox	ICS	Youth	Adult	Opioid Tx.	Youth (12 - 17)	Adult (over 17)
Unduplicated people served	2,532	1,999	2,432	135	1,422	8,244	3,086	13,941	130,809
Gender									
Number of people									
Male	935	1,719	1,704	110	1,018	5,515	1,651	7,178	59,047
Female	1,597	258	728	25	404	2,729	1,435	6,763	71,762
Percent of all served									
Male	37%	86%	70%	81%	72%	67%	53%	51%	45%
Female	63%	13%	30%	19%	28%	33%	47%	49%	55%
("Unknown gender" counts are not included)									
Race/ethnic group:									
Number of people									
African American	442	455	356	19	230	1,746	298	3,430	16,509
Asian/Pacific Islander	336	37	40	5	99	534	58	2,147	19,273
Caucasian/ White	951	875	1,425	87	555	4,146	2,042	6,009	82,073
Multi-racial	199	48	60	7	112	307	84	1,080	5,161
Native American	73	259	95	12	34	505	100	123	2,374
Other/ Unknown	531	325	456	5	392	1,006	504	1,152	5,419
Percent of all served									
African American	17%	23%	15%	14%	16%	21%	10%	25%	13%
Asian/Pacific Islander	13%	2%	2%	4%	7%	6%	2%	15%	15%
Caucasian/ White	38%	44%	59%	64%	39%	50%	66%	43%	63%
Multi-racial	8%	2%	2%	5%	8%	4%	3%	8%	4%
Native American	3%	13%	4%	9%	2%	6%	3%	1%	2%
Other/ Unknown	21%	16%	19%	4%	28%	12%	16%	8%	4%
	100%	100%	100%	100%	100%	100%	100%	100%	100%
Hispanic origin:									
Number of people									
Hispanic origin	519	201	140	5	391	749	193	2,623	14,994
Not Hispanic origin/Unknov	2,013	1,798	2,292	130	1,031	7,495	2,893	11,318	115,815
Percent of all served									
Hispanic origin	20%	10%	6%	4%	27%	9%	6%	19%	11%
Not Hispanic origin/Unknov	80%	90%	94%	96%	73%	91%	94%	81%	89%
	100%	100%	100%	100%	100%	100%	100%	100%	100%

(Percentages may not add up to 100% because of rounding)

Financial Summary

King County Substance Abuse Fund
2010 - 2012 Actuals
Financial Plan

	2010 Actual	2011 Actual	2012 Actual
Beginning Fund Balance	**3,779,516**	**3,641,370**	**3,901,637**
Revenues			
Licenses & Permits	0	0	
Federal Grants	4,492,615	6,597,503	2,583,140
State Grants	12,141,575	10,533,485	14,403,240
Intergovernment Payment	1,141,326	1,155,511	1,179,444
Charges for Services	474,043	663,226	597,692
Miscellaneous	37,644	70,477	21,157
Other Financing Sources	0	0	
Current Expense	0	0	
Total Revenues	**18,287,202**	**19,020,202**	**18,784,673**
Expenditures			
Administration	(2,078,560)	(1,859,830)	(1,789,867)
Housing Voucher Program *	0	0	
Treatment	(15,378,220)	(16,000,065)	(15,982,895)
Prevention Activities	(968,568)	(900,041)	(678,573)
Total Expenditures	**(18,425,348)**	**(18,759,935)**	**(18,451,335)**
Other Fund Transactions			
Adjustment Prior Yr Expenditures			
DCFM Energy Surcharge Refund			
Total Other Fund Transactions	**0**		
Ending Fund Balance	**3,641,370**	**3,901,637**	**4,234,975**



Appendices

Appendix A. Data Sources

This appendix describes the data sources used for the Chemical Dependency Performance Indicators Report (CDPIR) and issues around the quality, meaning and availability of the data. It also includes specific notes about the data presented for different program areas.

Data Sources

The data included in this report come from four broad types of sources:

- Summary data furnished by service providers. Such data are used for Emergency Services Patrol.
- A database developed by MHCADSD that is used by the Dutch Shisler Service Center and Involuntary Commitment Services to collect data for those programs.
- The State Prevention database that contains data from contracted providers about individuals who participate in multiple episode prevention programs.
- The State TARGET database that contains data from contracted providers about individuals and their treatment services. TARGET data are used for the Detoxification Center and Youth, Adult and Opioid Treatment Program outpatient treatment portions of the CDPIR. (Although the Sobering Support Center also submits data to the TARGET system, those data are not used in this report because only minimal TARGET data are collected for sobering services.)

Race/Ethnicity/Hispanic Origin Data Issues

Among the programs that are included in this report, there are a number of differences in how data about race, ethnicity and Hispanic origin are collected and/or reported. To combine the data into a single consistent format, the following decisions were made:

- The “race/ethnicity” data reported for all program areas is presented using a single set of categories.
- The categories chosen are four commonly identified broad “race/ethnicity” groups (Black/African American, White/Caucasian/European American/Middle Eastern, Asian/Pacific Islander and Native American/Alaska Native) and two other groups (Multi-racial and Other/Unknown).
- In those areas where the data collection system allowed more than one choice per person, any individual with data that “rolled up” into two or more different broad groups is counted as “Multi-racial” (White and Chinese, which rolled up to White and Asian-Pacific Islander, is counted as “Multi-racial”; Korean and Chinese as “Asian-Pacific Islander”).
- “Other” is grouped with “Unknown” into “Other/Unknown.”

Program-Specific Data Notes

Prevention

Prevention data shown in the report are from the state Prevention database. Providers report demographic data about individuals who participate in multi-session prevention programs but report only the total number of participants at single event prevention activities. Data about individuals include gender, age group, ethnicity and Hispanic origin.

Each multi-session program has a defined curriculum that is implemented with a registered group of participants who attend a prescribed number of sessions. Examples are Life Skills or the Nurturing Program. A single event is not an ongoing program but a prevention event that occurs once. Examples include a specific media campaign for graduation or prom time or a Health Fair.

Emergency Services Patrol

Individually identified data are not currently collected for this service.

Sobering Center (Dutch Shisler Service Center)

Data for services are entered into the MHCADSD chemical dependency database by sobering support center staff using the Sobering Center application.

Detoxification Center

Data for services at the Detoxification Center are entered into the TARGET data system by Detoxification Center staff. This report is based on downloaded data from that system.

A separate TARGET admission is reported for each level of care. To represent the true volume of admissions regardless of changes in level of care, only one admission is counted when a person had a prior TARGET detoxification admission that ended the day before the new TARGET admission date.

TARGET requires that data be reported about each person's "primary substance used" as reported by the person admitted and evaluated by the clinician. The Detoxification Center is not required to report data about the drug(s) for which the person is receiving detoxification services.

TARGET allows multiple referrals to be reported; however, the CDPIR uses only one referral for each discharge. Discharge referrals were counted based on the following hierarchy that generally orders the choices according to the intensity of response that the referral represents: ADATSA, ITS, CD TX, Self-help, Housing and Other ("Other" includes referrals for medical/dental, mental health and miscellaneous other resources). Those discharges with multiple referrals are reported based on whichever of those referrals is the highest in this hierarchy. Discharges that represent a transfer to a different level of care at the Detoxification Center are excluded to remain consistent with the admission data reported.

Involuntary Commitment Services

Data for Involuntary Commitment Services (ICS) referrals are entered into the integrated chemical dependency database by ICS staff using the ICS application. Data included are for referrals received and the disposition of referrals.

Outpatient Treatment: Youth, Adult and Opioid Treatment Programs

Data for all Outpatient programs are entered into the TARGET system by service providers; the CDPIR is based on those data.

The data used in this report are limited as follows:

- Only admissions where the TARGET "Fund Source" is "County Community Services" or there was a King County "Special Project Code" at some time during the admission are included. These conditions include admissions funded by MIDD. Those data indicate that the services are provided under contracts with King County.

- Data included for Youth and Adult are for the TARGET modalities of intensive outpatient, outpatient and MICA outpatient. Data for Youth are for all admissions where the client was under 18 years old on the admission date (for Adult, 18 years or over).

- Data for Opioid Treatment Programs are for all admissions where the TARGET modality is "Methadone/Opiate Substitution Treatment."

- Opioid Treatment Program admissions that were essentially transfers to another treatment location (often with the same provider) were combined. Such continuous treatment episodes were counted as a new admission only for the period when the first admission started and were counted as only one admission for any period in which the combined admissions were open.

The treatment retention rate is based on all admissions that started during a report period. If the discharge date minus the admission date is greater than 90 days, or the admission has not yet ended (no discharge date), it is counted as retained 91 or more days. The count of those admissions each biennial quarter is divided by the count of all admissions that started in the biennial quarter to calculate the percentage shown. This algorithm is different than the DBHR measure that also uses treatment activity data and discharge reasons to categorize the admissions counted for a retention rate. MHCADSD will review and revise the measure reported for the 2013 report to more closely track the DBHR measure.

Appendix B. Glossary

AAFT	Assertive Adolescent and Family Treatment Project
ACA	Affordable Care Act
A-CRA	Adolescent Community Reinforcement Approach
ACC	Assertive Continuing Care
ADATSA	The Alcohol and Drug Addiction Treatment and Support Act, which provides state-financed treatment and support to indigent people who are chemically dependent. ADATSA provides eligible people with inpatient and outpatient chemical dependency treatment and with limited financial support for housing and other needs.
AODPP	Alcohol and Other Drug Prevention Program
ATR	Access to Recovery
Biennial	Washington State's fiscal year is organized on a two-year basis, referred to as a biennium. Biennial quarters are one fourth of that period, or six months long. The biennium for this report began July 1, 2009 and ended June 30, 2011.
CD TX	Chemical Dependency Treatment
CDP	Chemical Dependency Professional
CDPT	Chemical Dependency Professional Trainee
CPPW	Communities Putting Prevention to Work
CRA	Community Reinforcement Approach
DBHR	Washington State Division of Behavioral Health and Recovery
EBP	Evidence-Based Practice
ESP	Emergency Services Patrol
GAIN	Global Appraisal of Individual Needs; A standardized bio-psychosocial assessment tool for people presenting for substance abuse treatment.
GAIN-I	The GAIN instrument used for an initial comprehensive assessment.
GAIN-SS	GAIN Short Screener. A quick tool used to screen for mental health and substance use diagnoses.

GAIN-M90	GAIN Monitoring 90 Days. A quarterly follow-up for monitoring how participants respond to treatment and/or do after they have been discharged.
JDCEP	King County Juvenile Drug Court Enhancement Project
ICS	Involuntary Commitment Services (see program description)
KCCOP	King County Community Organizing Program
MHCADSD	The Mental Health, Chemical Abuse and Dependency Services Division of the King County Department of Community and Human Services.
MICA	Mentally ill chemical abusers, also referred to as having co-occurring disorders. "MICA Outpatient" is a TARGET treatment modality.
MIDD	The Mental Illness and Drug Dependency Action Plan is a King County initiative funded with a one tenth of one percent sales tax to provide programs designed to stabilize people suffering from mental illness and chemical dependency, and to divert them from jails and emergency rooms by getting them proper treatment.
OTP	Opioid treatment program (see program description)
PHSKC	Public Health – Seattle & King County
PPW	Pregnant and Parenting Women
PRI	Prevention Redesign Initiative
ROSC	Recovery-Oriented System of Care
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, Referral to Treatment
SUD	Substance Use Disorder
TARGET	Treatment Assessment and Report Generation Tool is a data collection and reporting system maintained by the Washington State Department of Social and Human Services and contains data submitted by contracted treatment providers about the publicly funded chemical dependency treatment that they provide.
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy
WASBIRT-PCI	Washington Screening, Brief Intervention, Referral to Treatment – Primary Care Integration Project

Appendix C. Program Providers

Provider	Prev.	ESP	DSSC	Detox	ICS	Outpatient		OTP
						Youth	Adult	
Alpha Center for Treatment							x	
Asian Counseling and Referral Service						x	x	
Auburn Youth Resources	x					x		
Catholic Community Services							x	
Center for Human Services	x					x	x	
Community Psychiatric Clinic						x	x	
Consejo Counseling and Referral Service						x	x	
Downtown Emergency Service Center							x	
Encompass	x							
EvergreenHealth							x	
Evergreen Treatment Services								x
Friends of Youth	x					x		
Girl Scouts of Western WA	x							
Greater Maple Valley Community Center	x							
Harborview Medical Center Addictions Program							x	
Integrative Counseling Services						x	x	
Intercept Associates							x	
Kent Youth and Family Services						x		
King County Emergency Services Patrol		x						
King County Involuntary Commitment Services					x			
Lifelong AIDS Alliance	x							
Muckleshoot Indian Tribe						x	x	
Navos	**X**					x	x	
Neighborhood House	x**X**							
New Traditions							x	
Northshore Family and Youth Services						x		
Pioneer Human Services			x				x	
Recovery Centers of King County				x			x	
Renton Area Youth and Family Services	x					x		
Ruth Dykeman Youth and Family Services						x		
SafeFutures Youth Center	x							
SeaMar Community Health Centers						x	x	
Seattle Counseling Service						x	x	
Seattle Indian Health Board							x	
Seattle Public Schools	**X**							
Snoqualmie Indian Tribe						x	x	
Sound Mental Health						x	x	
Therapeutic Health Services						x	x	x
Valley Cities Counseling and Consultation							x	
Vashon Youth and Family Services	x**X**					x	x	
Washington Asian Pacific Islander Families Against Substance Abuse (WAPIFASA)	x					x		
Youth Eastside Services						x		

Prevention providers through June 2012 are shown with "x". Coalition providers are shown with "**X**".